DOCUMENT RESUME

ED 256 540 RC 015 249

AUTHOR	Strazicich, Mirko, Ed.
TITLE	Guidelines for Health Services for Migrant Students.
INSTITUTION	California State Dept. of Education, Sacramento. Bureau of Community Services and Migrant Education.
PUB DATE	84
NOTE	58p.; Best copy available.
AVAILABLE FROM	California State Department of Education, P. O. Box 271, Sacramento, CA 95802-0271.
PUB TYPE	Guides - Non-Classroom Use (055)
EDRS PRICE	MF01 Plus Postage. PC Not Available from EDRS.
DESCRIPTORS	Child Abuse; Elementary Secondary Education; Guidelines; *Health Education; Health Materials; *Migrant Children; *Migrant Health Services; Nutrition; Physical Examinations; *Physical Health; *School Health Services; Screening Tests; *State Legislation
IDENTIFIERS	*California; Migrant Student Record Transfer System; Scoliosis

ABSTRACT

This publication provides a standard by which California migrant education health staff can plan, implement, and evaluate a health program for students in grades K-12. Following sections which describe current state legislation, the need for health services, and California's objectives and activities regarding health services for migrant students there is a section which defines health and support services in 13 specific areas. These areas are: physical examination, hearing screening, vision screening, scoliosis screening, immunizations, dental screening, nutrition, child abuse, mental health and counseling, health education for students, health education for staff, health education for parents, and the Migrant Student Record Transfer System (MSRTS) medical record. State-mandated health requirements, the rationale for supplemental services, methods of providing supplemental services, and community resources are outlined for each of the 13 areas. Nine appendices cite portions of state education, health and safety and penal codes which directly support the areas outlined in the health and support services section. The 10th and last appendix gives an example of the MSRTS migrant student health record. (PM)

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Guidelines for Health Services for Migrant Students

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Publishing Information

This guide, which was prepared under the general direction of Joan Ainslie, Health Consultant, Migrant Education Office, California State Department of Education, was designed to serve as a model for the schools, not a mandate. The document was edited by Mirko Strazicich and prepared for photo-offset production by the Bureau of Publications. Artwork was created by Cheryl Shawver McDonald, with typesetting by Anna Boyd and Leatrice Shimabukuro. The document was published by the Department of Education, 721 Capitol Mall, Sacramento, CA 95814-4785; printed by the Office of State Printing; and distributed under the provisions of the Library Distribution Act and *Government Code* Section 11096.

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Preface

The challenge of applying guidelines to a program designed to serve a moving population such as the migrant farmworkers is a difficult one. In the area of health care, the challenge is compounded by various problems such as access to low-cost quality medical care, availability of health education information in the appropriate language, and an accurate medical recordkeeping system after health care is given. In California, where some of the most modern medical technology exists, these problems continue to affect the migrant farmworker.

The guidelines in this document should provide a structure which can be used to deal with these problems. The document also contains a listing of the health screenings that are mandated by the California State Legislature and the names of appropriate local community resources. These resources are especially important in light of the ever-dwindling supply of health care funds provided by government agencies.

This type of document is needed because of the variations of health care programs among regions and direct-funded districts throughout the state. These guidelines include information to strengthen the overall state migrant education program and to reduce the number of barriers which migrant farmworker families and their children encounter as they travel across the state and country.

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Acknowledgments

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Introduction

Medical, dental, nutritional, social, and psychological services are essential adjuncts to an effective educational program because they enable students to achieve their greatest potential in learning and healthful living. The guidelines in this document should help migrant education staffs to provide these necessary services to students in kindergarten through grade twelve.

The primary purpose of the *Guidelines for Health Services for Migrant Students* is to promote uniformity and continuity of health services provided by migrant education programs throughout California. The guidelines provide a standard by which each migrant education health staff can plan, implement, and evaluate a health program.

The development of these guidelines was begun in response to a request by the Acting State Director of Migrant Education. Up to that time migrant education health programs had varied widely from region to region. Representatives of health program staffs in five regions were named to a committee. After reviewing mandated screenings and studies identifying health needs of migrant students, the committee developed methods which should enable migrant education staffs to meet their students' special needs. The committee also realized that not all treatable health problems are referred as a result of a health screening such as a physical examination. Many times the staff member becomes aware of a health concern by way of the parents, the classroom teacher, or the student. In these cases the appropriate follow-up treatment should be provided. The committee has identified community resources which should be explored first in order to ensure that funds for migrant health services remain supplemental.

This effort has proved to be rewarding and educational for those who have worked on this project. These guidelines should provide any migrant education program, large or small, with procedures that can be used to ensure optimum health for every migrant child in California.

Enabling Legislation

The importance of optimal health in helping migrant students to achieve their maximum educational potential has been recognized and addressed by legislation at both the federal and state levels. This legislation defines the eligibility of the migrant child and allows for the provision of supplemental health and support services to eligible migrant children.

Under the California Master Plan for Migrant Education of 1976, the state is the prime contractor to the federal government for the migrant education program operated with ESEA, Title I, funds. The purpose of this program is to provide appropriate supplemental instructional and health and welfare services for migrant pupils. The Master Plan states that migrant children must receive diagnosis and treatment of any health problems that interfere with their education. Any services provided by public health agencies must be supplemented by services provided under the plan.

In accordance with the *Federal Register* of April 3, 1980, Section 116d.51, the state educational agency may provide health, nutritional, social, or other supporting services with migrant education funds if these services are necessary to enable eligible migrant children to participate effectively in instructional services. The state educational agency's plan must include an assessment of the educational needs of the children eligible to be served. That description must include needs with respect to reading, oral language, mathematics, career awareness, and speaking ability in English and must demonstrate that the state educational agency has obtained an accurate assessment of the cultural and linguistic backgrounds of the children. That description must also include needs with respect to supporting services, such as health, nutritional, and social services.

Education Code Section 54441 describes two categories of migrant children:

1. A currently migratory child is a child who has moved with a parent, guardian, or other person having custody, from one school district to another, either within California or between California and another state within the 12-month period immediately preceding his or her identification as such a child. The term *currently migratory child* includes any child who, without the parent or guardian, has continued to migrate annually to

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secure temporary or seasonal employment in an agricultural or fishing activity.

2. A former migratory child is a child who was formerly eligible to be counted and served as a currently migratory child within the last five years, but who is no longer a currently migratory child, and who lives in an area served by an ESEA Title I Migrant Education project.

Education Code Section 54443 states that migrant children must be served according to their needs in the following order:

1. School-aged currently migratory children
2. School-aged former migratory children
3. Preschool currently migratory children
4. Preschool former migratory children

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Statement of Need

A number of factors have prevented migrant students from obtaining necessary health services in California. Some of these factors are:

1. Excessive mobility of migrant families
2. Lack of bilingual health care personnel
3. Limited knowledge of available health services
4. Residency requirements for Medi-Cal eligibility
5. Lack of health insurance for most farmworker families
6. High cost of medical/dental care
7. Families residing in medically under-served areas
8. Lack of awareness of preventative health measures

These problems have been the subject of many studies. One published document, the *Migrant Health Report of the Education Commission of the States*[1], made the following conclusions:

> Young migrant children in California, as in other great migrant streams in the United States, have a number of health problems that are apt to affect their development and school performance:
>
> 1. They have a poor record of immunization and dental care.
> 2. The height and weight measurements of a sizable proportion of migrant children show the stunting effects of poor or marginal nutrition.
> 3. The health histories and physical examinations reflect the synergistic interaction of marginal nutrition, diarrhea, chronic respiratory and parasitic infections, as well as exposure to repeated accidents and injury.
> 4. Singly, and in combination with a higher than average incidence of vision and hearing problems, poor health and nutritional status have a cumulative effect on the children's development.
> 5. Together with frequent changes of residence that deprive them of health care and followup, and lack of exposure to the English language, those health problems are apt to lead to difficulties in school.

A 1979 study made for the National Early Periodic Screening, Diagnosis and Treatment Program showed that:

- Ten percent of all children between the ages of six and eleven have vision problems. Only 40 percent of children in low-income

[1] *Migrant Health Report of the Education Commission of the States.* Denver: Education Commission of the States, 1979.

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families between the ages of six and eleven have these known vision handicaps corrected.

- Ninety-six percent of all children require some dental care before age six. Only 40 percent of the children in low-income families have ever seen a dentist before age seventeen.
- Of the 15.2 percent of one group of eighteen-year-old males who had disabilities, it was determined that 63 percent of these conditions could have been prevented or corrected before the individual reached age fifteen.

These statistics reflect some of the health problems of low-income children nationwide. Such problems are made even more difficult for the migrant child because of the barriers mentioned previously.

Primary health care centers with outreach components that provide treatment regardless of the individual's ability to pay are often inaccessible. Even when services exist in an area, they are underutilized by the community they are intended to serve. In addition to financial and language accessibility, health care services often lack cultural relevance or consideration for the nonclinical aspects of the healing process, including family and community support mechanisms for the individual (California Raza Health Plan, October, 1979).

The primary responsibility for the health needs of the migrant student lies with the parent or guardian; however, migrant education health personnel can play an advocacy role in helping the parent or guardian obtain the health care that the migrant student requires.

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Objectives and Activities

In accordance with the California Master Plan for Migrant Education, the purpose of the health and supportive services component is to assist eligible migratory children to obtain medical, dental, and/or social services necessary for effective participation in instructional services. These services are obtained through creating linkages between state and local agencies and other organized groups that provide benefits and services. When it has been determined that funds or services from other programs are not available or are inadequate to meet the needs of the participating migratory children, these services may be provided by the operating agency.

Objectives

The California State Department of Education will assist local educational agencies (LEAs) to do the following:

1. Ensure that migrant children participate in all federal and state-mandated school health services (for example, Search and Serve under Public Law 94-142, periodic vision and hearing tests, scoliosis screening, Child Health Disability Prevention Program, and documentation of minimal immunizations).
2. Identify physical, emotional, and social problems that interfere with the educational process.
3. Remediate identified health problems that interfere with the migrant child's educational process.
4. Maintain current medical information on each migrant child through the use of Migrant Student Record Transfer System (MSRTS).
5. Provide health education to migrant students, their parents, and migrant education staff to increase their level of awareness concerning preventive health measures.
6. Refer handicapped students who are seventeen years of age or in their eleventh year of school to the local Department of Rehabilitation office for prevocational counseling and development based on medical and vocational evaluation, aptitude assessment, functional limitations, and interests.
7. Establish working liaisons at the local levels for the identification of handicapped students for referral to the local Department of Rehabilitation office.

Activities

The Department will assist operating agencies to do the following:

1. Provide migrant children with periodic health screening as needed.
2. Identify emotional and social problems of migrant children.
3. Develop a directory of agencies and organizations that may be used to provide health and social services to migrant children and their families.
4. Facilitate the remediation of identified health and social problems through the use of available health and welfare services.
5. Provide transportation and translation assistance, as needed, to obtain health and welfare services.
6. Maintain trained staff to record pertinent health data for the MSRTS.
7. Disseminate pertinent health data contained on the MSRTS records to appropriate health and school personnel and parents.
8. Work closely with all levels of parent advisory committees.
9. Encourage parents to maintain current health records for their children.
10. Work with school and community resources to provide in-service training to migrant education staff, students, and parents.

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Health and Support Services

These guidelines are designed to provide a framework from which educators can develop and implement a health component for migrant students. The system established in California for assessing the individual educational and health needs of each migrant child provides a data base upon which teachers and administrators can plan programs to ensure comparable access and to address unique needs.

The needs assessment process meets numerous requirements set forth in federal and state mandates. Assessment components relating to each student's needs in the health and support service area include the following: vision, hearing, and dental screening; physical examination; immunization; nutrition; health education; health follow-up; and counseling services.

The school-level plan should summarize the needs of all migrant students in a given school. By utilizing the school-level plan, the staff can prioritize student needs, document services received by migrant students from other programs, and develop activities designed to fill whatever gaps exist between the students' needs and other program offerings. Thus, by utilizing the needs assessment process and these guidelines, the migrant education program staff seeks to ensure a relevant and equal educational opportunity for children of migrant farmworkers by helping school districts to meet the special needs of these children.

These guidelines focus on the delivery of supplemental health and support services. The appendixes detail those health services mandated for all California schoolchildren.

Each area of health services is presented in four sections:

1. *State-mandated health requirements.* This section contains a brief description of the services that must be provided to all students enrolled in California schools. The specific regulations and codes are presented in the appendixes. In addition, official publications outlining procedures for implementation of the law are listed. The premise is always that migrant students are members of the school population first; any services provided by the Migrant Education Program must be supplemental to the state-mandated services.

2. *Rationale for supplemental services.* Factors which contribute to the necessity for providing additional services to migrant students are identified.
3. *Methods of providing supplemental services.* This section describes processes for utilizing migrant staff and resources to offer medical screening, remediation, and education to students and/or parents.
4. *Community resources.* This section lists agencies that might be approached to serve the unmet health needs of students. Many communities have resource guides listing social service and health agencies. When all other resources have been exhausted, Migrant Education Program funds may be used for remediation.

Physical Examination

State-Mandated Health Requirements

First-grade students must meet the requirements of the Child Health and Disability Prevention Program (*Health and Safety Code* sections 320, 320.2, and 320.5). (See Appendix A.)

Rationale for Supplemental Services

Because of poverty and high mobility, many migrant children have never had a complete physical examination. Chronic and acute health problems which interfere with the child's learning are often undetected and untreated. The American Academy of Pediatrics and the Child Health and Disability Prevention Program recommend that all children have a physical examination every three years. California's Migrant Education Program follows those guidelines.

Methods of Providing Supplemental Services

Members of the migrant education staff should do the following:

1. Review each student's MSRTS and school health records to identify those students who (a) have not had a physical examination within the last three years; or (b) need medical follow-up for an existing problem.
2. Meet with the child's family regarding:
   a. The child's need for a physical examination or medical follow-up
   b. Identification of the family's own resources (including Medi-Cal and private insurance coverage)
   c. Eligibility for community services
   d. Development of a plan for obtaining a physical examination or medical follow-up for the child (including transportation and translation services, if needed)
3. Use migrant education funds for physical examinations or necessary medical follow-up only when all other resources have been exhausted.
4. Notify appropriate school personnel of health problems that interfere with the child's learning or limit his or her participation in school activities. This should be done only with the consent of the parent or guardian.

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5. Work with school personnel to see that the regular school program will be modified to accommodate the student's individual needs, if necessary.
6. Update each student's MSRTS records with results of the physical examination and follow-up treatment.

Community Resources

School nurses
Easter Seal Society
California Children's Services
Medi-Cal
Lions, Elks, and other service clubs
Mental health departments or agencies
Welfare and other social agencies
Law enforcement agencies
March of Dimes
Economic Opportunity Commission (EOC)
Emergency housing and food service agencies
Outreach, Salvation Army, and other such service agencies
Private insurance agencies
Shriners
Rural clinics
Hill-Burton legislation
Church-affiliated organizations
Rural health agencies
Public health departments
Providers of private health care services

Hearing Screening

State-Mandated Health Requirements

A hearing screening program is conducted for students in kindergarten and grades one, two, five, eight, and ten or eleven (*Education Code* sections 49451, 49452, and 49454 and *California Administrative Code, Title 17, Public Health,* sections 2950 and 2951), and for new enrollees and referrals. (See Appendix B.)

Rationale for Supplemental Services

Inadequate environmental conditions often foster hearing problems. Because of high mobility, migrant students may not be present when routine school hearing screenings are done. Therefore, hearing problems often remain undetected and untreated.

Methods of Providing Supplemental Services

Members of the migrant education staff should do the following:

1. Review each student's MSRTS and school health records to identify those students who (a) have not had a hearing screening within the last two years; (b) have failed a previous hearing screening; or (c) have a history of chronic or acute ear infections.
2. Arrange for hearing screening for migrant students in need.

3. Meet with the family when a migrant child has failed two successive hearing screenings or has a history of chronic or acute ear infections. This meeting should cover the following:
   a. The child's need for further hearing evaluation tests or follow-up care
   b. Identification of the family's own resources (including Medi-Cal and private insurance coverage)
   c. Eligibility for community services
   d. Development of a plan for obtaining further hearing evaluation tests or follow-up medical care (including transportation and translation services, if needed)
4. Use migrant education funds for hearing evaluation tests and follow-up medical costs only when all other resources have been exhausted.
5. Notify appropriate school personnel of any hearing problem which interferes with the child's learning or limits his or her participation in school activities.
6. Work with school personnel to see that migrant children who have an identified hearing loss receive all support services needed (for example, preferential seating, evaluation by a specialist for the hard of hearing, and speech therapist services).
7. Update each student's MSRTS and school health records with results of hearing screenings and follow-up treatment.
8. Coordinate program efforts with school health personnel at the state, county, and local levels.

Community Resources

School nurses/public health nurses
County health departments
California Children's Services
Migrant clinics
Rural health clinics
Hill-Burton legislation
Private medical practitioners
County audiologists

Vision Screening

State-Mandated Health Requirements

A vision screening program is conducted for students in kindergarten and grades three and six (*Education Code* Section 49455), grades nine or ten (Motor Vehicle Code Section 12805), and for new enrollees and referrals.

Color vision screening is conducted for boys in kindergarten or first grade (*Education Code* Section 49455). (See Appendix C.)

Refer to *A Guide for Vision Screening in California Public Schools*[2] for procedures and methods used to administer a program.

[2]*Guide for Vision Screening in California Public Schools.* Sacramento: California State Department of Education, 1984.

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Rationale for Supplemental Services

Because of mobility, migrant students may not be present when routine school vision screenings are conducted. Therefore, vision problems are often undetected and untreated.

Methods of Providing Supplemental Services

Members of the migrant education staff should do the following:

1. Review each student's MSRTS and health records to identify students who have not received a vision exam within the last three years or who have a possible vision problem needing remediation.
2. Arrange for vision screening for those migrant students who need screening.
3. Be responsible for follow-up care, if needed, by:
   a. Meeting with family to (1) discuss the need for further vision evaluation in light of screening results; (2) identify family's own resources; and (3) determine eligibility for community resources.
   b. Developing with the family a plan for obtaining vision care.
4. Use migrant education funds for further vision evaluation and remediation, if needed, when all resources are exhausted.
5. Inform school staff of student's vision status and needs.
6. Follow up to see that the student's classroom environment is modified, if needed. (This may include sitting close to chalkboards, being evaluated by teacher of visually handicapped, and using large print books.)
7. Records all information on MSRTS records.
8. Coordinate program efforts with school health personnel at state, county, and local levels.

Community Resources

School nurses and public health nurses
Lions Club and other service organizations
Private optometrists, ophthalmologists
California Children's Services
Sliding-fee-scale clinics

Scoliosis Screening

State-Mandated Health Requirements

Scoliosis screening is conducted for seventh-grade girls and eighth-grade boys (*Education Code* Section 49452.5). (See Appendix D.)

Refer to the *Standards for Scoliosis Screening in California Public Schools*[3] for procedures and methods used to administer a program.

Rationale for Supplemental Services

Scoliosis occurs during the rapid growth period of adolescence. This rapid growth may begin as early as ten years or as late as fourteen years. Students, both male and female, need scoliosis screening annually during these critical growth years. Migrant students may miss screening in schools.

[3] *Standards for Scoliosis Screening in California Public Schools.* Sacramento: California State Department of Education, 1984 (in process).

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Methods of Providing Supplemental Services

Members of the migrant education staff should do the following:

1. Review MSRTS records to determine migrant students who (a) have not received scoliosis screening; or (b) have failed previous scoliosis screening.
2. Make arrangements for scoliosis screening.
3. Meet with parents of students who fail scoliosis screening to:
   a. Discuss (1) what was found in the screening; (2) ramifications of scoliosis; and (3) the need for further evaluation.
   b. Identify family resources for care.
   c. Determine eligibility for community resources.
   d. Develop a plan for care.
4. Use migrant education funds for transportation and translation only when all other resources are exhausted.
5. Record all information on MSRTS and school health records.
6. Coordinate efforts with the local school health personnel and community agencies.

Community Resources

School nurses and public health nurses
Private physicians
Clinics
California Children's Services

Immunizations

State-Mandated Health Requirements

Refer to the *School Immunization Handbook*[4] for procedures and methods used to administer a program as well as for most current immunization regulations. (See Appendix E.)

Rationale for Supplemental Services

Migrant students may be excluded from school because they fail to meet the state immunization admission requirements. Migrant parents are often unsure of which immunizations are required, which immunizations their children have already received, and where to go to receive the immunizations needed.

Methods of Providing Supplemental Services

Members of the migrant education staff should do the following:

1. Work with school personnel to identify students who are in need of immunizations.
2. Discuss during the conference with parents:
   a. The child's need for immunizations
   b. Development of a plan for obtaining the needed immunizations (including transportation and translation services, if needed)
   c. Notification of school personnel about immunizations received

[4]*School Immunization Handbook*. Sacramento: California State Department of Health Services, 1981.

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3. Use migrant education funds when all other resources have been exhausted.
4. Update each student's MSRTS and school health records with information about immunizations received.

Community Resources

Public health agencies
Rural health clinics
Schools
Migrant clinics
Private doctors

Dental Screening

State-Mandated Health Requirements

None. (See Appendix F for the *Education Code* requirements for a community dental disease prevention program.)

Rationale for Supplemental Services

Dental disease is the major health problem of school-age children. Dental care is a low-priority item in some families. Migrant families seldom have dental health insurance or adequate funds to obtain professional dental treatment.

Methods of Providing Supplemental Services

Members of the migrant education staff should do the following:

1. Review each student's health and MSRTS records to identify (a) children who have not had dental screening in the past two years; and (b) children who have dental caries that have not been repaired.
2. Arrange for dental screening of students who have not been screened.
3. Be responsible for contacting parents of those students needing dental care. During conferences with parents, a staff member should (a) discuss the need for dental care; (b) identify family resources for care; (c) determine eligibility for community resources; and (d) develop a plan for care, if possible.
4. Use migrant education funds for dental care, transportation, and translation in accordance with criteria established by each operating agency and only when all other resources have been exhausted.
5. Record information on MSRTS and school health records.

Community Resources

School nurses and public health nurses
Parents
Medi-Cal (Denti-Cal)
California Children's Services (orthondontia only)
Community agencies
County health agency
Private dentists and hygienists

Regional rural health agencies
Mobile dental clinic programs
Rural health clinics
Sliding-fee-scale clinics

Nutrition

State-Mandated Health Requirements

Schools and child development programs have an obligation to provide for the nutritional needs and nutrition education of all students during the school day (Public Law 94-105). (See Appendix G.)

Rationale for Supplemental Services

Inadequate nutrition may lead to anemia, weight loss, and other health problems. Federal guidelines indicate that families living at the poverty level have a higher incidence of poor nutrition.

Methods of Providing Supplemental Services

Members of the migrant education staff should do the following:

1. Assist migrant students in obtaining school lunches and breakfasts if necessary.
2. Measure the student's weight and height and plot them on a growth chart if a student appears to be undernourished or overnourished.
3. Obtain a hemoglobin/hematocrit to check for anemia if a student appears to be undernourished.
4. Meet with the student's family to identify nutritional problems and develop a plan for care. This may include referral for medical evaluation and treatment, counseling regarding basic nutrition, and helping the family to obtain food.
5. Provide classes on nutrition for parents and students.[5]
6. Use migrant education funds only when all other resources have been exhausted.

Community Resources

School nurse and public health nurse
School lunch/breakfast program
Child care services
Economic Opportunity Commission
Community Action Organization (CAO)
Women, Infants, and Children (WIC) Section in the State Department of Health Services
Private providers
Rural health clinics
Local health agencies
Office of Child Nutrition Services in the State Department of Education
University of California Cooperative Extension
Extended Food and Nutrition Program (EFNP)

[5]See *Nutrition Education—Choose Well, Be Well* series of books listed with other Department of Education publications on page 48.

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Child Abuse

State-Mandated Health Requirements

When a minor comes to the attention of a medical, school, welfare, or probation official and the minor appears to have physical injuries inflicted by other than accidental means or the minor has been sexually molested, the official must report such fact by telephone and in writing, within 36 hours, to both the local police authority having jurisdiction and to the probation department or the county welfare department.

The report must state, if known, the name of the minor, his or her whereabouts, and the character and extent of the injuries or molestation, physical and emotional abuse, and/or injury.

If a parent of a minor child wilfully neglects to furnish necessary clothing, food, shelter, or medical assistance, or other remedial care for his or her child or fails to protect a child from severe malnutrition (Penal Code Section 11165), he or she is guilty of a misdemeanor punishable by a $500 fine or imprisonment. (See Appendix H.)

Refer to *Child Abuse, the Educator's Responsibility*[6] and *Child Abuse Prevention Handbook.*[7]

Rationale for Supplemental Services

Migrant children may suffer from child neglect or child abuse due to a lack of economic resources and insufficient awareness of community support systems on the part of the parents.

Methods of Providing Supplemental Services

Members of the migrant education staff should do the following:

1. Increase awareness of staff members in their legal responsibility in the child abuse/neglect law.
2. Increase migrant parent awareness of community resources for child abuse/neglect.
3. Increase the awareness of community agencies about the migrant family life-style and culture.
4. Use the sensitive data code and list appropriate information in the contact data section of the MSRTS record.

Community Resources

School nurses and public health nurses
Religious counseling services
Child care services
Probation and police departments
County mental health agency
Private mental health practitioner
Multicultural Child Abuse and Neglect Council
Women's centers
Community providers of clothing and food

[6] *Child Abuse, the Educator's Responsibility*. Sacramento: California State Department of Justice, 1981.

[7] *Child Abuse Prevention Handbook*. Sacramento: California State Department of Justice, 1982.

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Mental Health and Counseling

State-Mandated Health Requirements

None.

Rationale for Supplemental Services

Few studies can document that the migrant population has more mental health problems than the nonmigrant population. However, when mental health problems do occur, there is underutilization of community resources by migrant families. Some migrant families may be reticent about seeking mental health services. Others who try to obtain help may be told that an outreach program is not available in their area.

Methods of Providing Supplemental Services

Members of the migrant education staff should do the following:

1. Meet with the migrant family to:
   a. Discuss need for counseling.
   b. Identify family resources for care.
   c. Determine eligibility for community resources.
   d. Develop a plan for care.
2. Use migrant education funds for transportation and translation services but only when all other resources are exhausted.
3. Provide in-service training for staff to increase awareness of student behaviors which may indicate a need for counseling.
4. Provide classes in parenting when appropriate.
5. Work with agencies to increase awareness of migrant family life-style and values (if needed).
6. Record information on MSRTS records, using the sensitive data code.

Community Resources

Mental health agencies
Youth clinic
Family service agencies
School nurses and counselors
Religious counseling services
Private agencies

Health Education for Students

State-Mandated Health Requirements

The goal of the mandated health education program is to prepare students to assume responsibility for their own health and the health of their families and communities. (See Appendix I.)

Refer to the *Health Instruction Framework for California Public Schools.*[8]

Rationale for Supplemental Services

The health needs of migrants in all areas, including disease prevention, are critical. Because of inconsistent school attendance and class

[8] *Health Instruction Framework for California Public Schools.* Sacramento: California State Department of Education, 1978.

discussions which are not in their first language, many migrant students miss out on the information provided in health classes. Also, because of the lack of knowledge of preventive health measures on the part of some parents, appropriate role models may not be available in the home environment.

Methods of Providing Supplemental Services

Members of the migrant education staff should do the following:

1. Increase the number of health education classes and provide health education materials in appropriate languages.
2. Compile and develop health education curricula and materials to be used in migrant summer school.
3. Make available health education information to the migrant education staff.
4. Create linkages with community agencies in order to provide health education in appropriate languages.
5. Coordinate efforts with school health personnel.

Community Resources

School nurses and public health nurses
School district staff
State school health staff
Family planning clinics
Family planning service agencies
Public health agencies
University health education programs
Medi-Corps students (California Migrant Mini-Corps Program)
Health-related agencies, such as the March of Dimes and the Heart Association

Health Education for Staff

State-Mandated Health Requirements

None.

Rationale for Supplemental Services

To explain health information to migrant students accurately, staff members need to be aware of the most current materials and information available.

Methods of Providing Supplemental Services

Members of the migrant education staff should do the following:

1. Conduct in-service training sessions and workshops for all staff members.
2. Increase staff's awareness of available community health education agencies.
3. Attend workshops presented by the School Health Education Unit, California State Department of Education.

Community Resources

See "Community Resources" under "Health Education for Students."

Health Education for Parents

State-Mandated Health Requirements

None.

Rationale for Supplemental Services

Needs assessments done with migrant parents indicate a desire for more information on various health topics (for example, first aid, pesticide poisoning, dental health, and family planning).

Methods of Providing Supplemental Services

Members of the migrant education staff should do the following:

1. Ask parents what they want in the area of health education and provide the information requested.
2. Encourage parents to make positive changes in their health practices.
3. Coordinate efforts with the school health and special education services in the California State Department of Education.

Community Resources

See "Community Resources" under "Health Education for Students."

MSRTS Medical Record

State-Mandated Health Requirements

The Migrant Student Record Transfer System (MSRTS) provides computerized record transfer services throughout the United States and Puerto Rico.

All schools that serve migrant children are *required* to use the MSRTS.

Medical records include immunizations, physical examinations, family history, screening data, recent health providers, problem list, and listing of unresolved health problems.

Rationale for Supplemental Services

The MSRTS helps to provide continuity of health and school records for migrant students. (See Appendix J.)

Methods of Providing Supplemental Services

Members of the migrant education staff should do the following:

1. Participate in in-service training on the use of the MSRTS.
2. Record all pertinent information on the MSRTS records in a timely manner.
3. Use MSRTS information for needs assessment and health program planning.
4. Know how to obtain critical medic-alert data.

Community Resources

School nurses and public health nurses
School health records
Parents
Health care providers

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Appendix A

Child Health and Disability Prevention Program

***Health and Safety Code* sections 320, 320.2, 320.5, 321.2, 321.7, and 323.5**

Legislative Finding and Declaration

320. The Legislature finds and declares that many physical and mental disabilities can be prevented, or their impact on an individual lessened, when they are identified and treated before they become chronic and irreversible damage occurs. The Legislature finds and declares that a community-based program of early identification and referral for treatment of potential handicapping conditions will be effective in reducing the incidence of such conditions and will benefit the health and welfare of the citizens of this state.

It is the intent of the Legislature in enacting this article to establish child health and disability prevention programs, which shall be financed and have standards established at the state level and which shall be operated at the local level, for the purpose of providing early and periodic assessments of the health status of children. It is further intended that child health and disability prevention programs shall make maximum use of existing health care resources and shall utilize, as the first source of screening, the child's usual source of health care so that health screening programs are fully integrated with existing health services, that health care professionals be appropriately represented and utilized in these programs, that outreach programs be developed to stimulate the use of preventive health services, and that services offered pursuant to this part be efficiently provided and be of the highest quality.

320.2. As used in this article:

(a) "State board" means the State Maternal, Child, and Adolescent Health Board.

(b) "Department" means the State Department of Health Services.

(c) "Director" means the State Director of Health Services.

(d) "Governing body" means the county board of supervisors or boards of supervisors in the case of counties acting jointly.

(e) "Local board" means local maternal, child, and adolescent health board.

(f) "Local health jurisdiction" means county health department or combined health department in the case of counties acting jointly or city health department within the meaning of Section 1102.

320.5. A State Maternal, Child, and Adolescent Health Board advisory to the director is hereby established within the State Department of Health Services.

The state board shall consist of 13 voting members. The membership shall reflect the ethnic and geographic diversity of the State of California and shall include individuals or parents of individuals who are recipients of services administered by the department, health providers, including Board of Medical Quality Assurance certified or qualified physicians, and representatives of other related interests. The Governor shall appoint seven members of the state board, including a county health officer; a member of the Primary Care Clinics Advisory Committee; one family practice physician, one dentist a major part of whose practice is children's dentistry; one pediatrician; one representative of a child health advocacy organization; and one parent, who is not a health care provider, of a child eligible for health services administered by the department. The Chairman of the Senate Rules Committee shall appoint three members of the state board, including a pediatrician, a parent, who is not a health care provider, of a child eligible for health services administered by the department, and an individual experienced in administering a local family planning agency. The Speaker of the Assembly shall appoint three members of the state board, including

a pediatrician, a nurse specializing in child health, and an obstetrician/gynecologist. A member of the State Council on Developmental Disabilities, a member of the State Commission on Special Education, the Directors of the Departments of Health Services, Mental Health, and Social Services and the Superintendent of Public Instruction, or their designees, shall serve as ex officio, nonvoting members of the state board. The term of each member shall be three years, or for the duration that each member maintains the qualifications under which he or she was appointed, whichever is shorter. In order to maintain continuity, present members of the State Child Health Board shall be appointed to the state board for the duration of their current terms.

The members of the state board shall serve without compensation but shall be reimbursed for any actual and necessary expenses incurred in connection with the performance of their duties under this article. Members who are parents of children eligible for departmental programs may additionally be reimbursed upon request for their actual and necessary costs of additional child care and lost wages. The Director of Health Services shall provide necessary support staff and services to the state board. The state board shall utilize available department staff to carry out specific tasks enumerated in this article. The state board may hire staff for special projects provided the total budget level for board operations does not exceed the existing level, except as provided for by the director or the Legislature by statute.

The state board shall select its own chairperson from among the 13 appointed members by majority vote of the members and shall establish technical advisory committees as it deems necessary and desirable for the efficient and expeditious performance of its duties. The director may provide or the state board may request that the director provide additional technical experts and consultants to facilitate and support the work of the state board. The state board shall meet on call of the chairperson, at least once quarterly, or as often as necessary to fulfill its duties. All meetings and records of the state board shall be open to the public.

The state board shall have all of the following powers, duties and responsibilities:

(a) Conduct independent studies, investigations, and hearings on the health of mothers, children, and adolescents and the system of health services for mothers, children, and adolescents.

(b) Review health related programs which serve women, children, and adolescents for the purpose of recommending steps to facilitate interdepartmental integration of service delivery.

(c) Identify deficiencies and barriers in the maternal, child, and adolescent health delivery system on a statewide basis, recommend priorities for remedying deficiencies, and develop recommendations to remove barriers to appropriate health service utilization.

(d) Review, during the developmental stage, any plans affecting health programs for mothers, children, and adolescents developed by the department and comment on such plans vis a vis consistency with the state board's policy and goals and make recommendations on a unified planning process for programs affecting the health of mothers, children, and adolescents.

(e) Receive from the department for review and comment prior to their adoption all rules, regulations, and standards affecting maternal, child, and adolescent health. The director shall submit to the board a copy of the final statement prepared for the Office of Administrative Law pursuant to Section 11346.7 of the Government Code. The director may impose a reasonable time limit for the review of regulations, including, but not limited to, the following:

(1) Review of standards for health screening, evaluation, and diagnostic procedures for community maternal, child, and adolescent health programs.

(2) Review of standards for directors of community maternal, child, and adolescent health programs.

(3) Review of standards for public and private health providers, facilities, and agencies which participate in community maternal, child, and adolescent health programs.

(f) Review and comment upon proposed department policies affecting maternal, child, and adolescent health programs.

(g) Review policies and develop recommendations regarding:

(1) Health goals with measurable objectives for all children, adolescents, and pregnant females in California.

(2) A standard of financial eligibility for preventive programs which will facilitate program integration.

(3) A reimbursement mechanism that will encourage provider participation in an integrated maternal, child, and adolescent health program.

(4) Current programs that could be combined to foster integrated service delivery.

(5) Systems to assure coordination within the department in order to insure uniform case management and referral of children, youth, and pregnant women.

(6) Coverage of preventive care, health maintenance, and health education and counseling by third party payers.

(h) Review reports and respond to needs and recommendations of the local boards.

(i) Work with local boards to evaluate the success of established programs and assess the potential viability of proposed programs.

(j) Review and make recommendations to the director on written appeals received from local organizations and providers.

(k) Prepare a biennial report to the director summarizing the progress of the state board in fulfilling the above listed duties, powers and responsibilities, which report shall be transmitted to the Legislature and the local boards. The first such report shall be due on or before January 1, 1983.

In order to further the intent of this section and to support the work of the state board, the department shall develop, not later than July 1, 1982, alternative models for the provision of integrated health service delivery to women, children, and adolescents at the local level. Such models shall address the concerns and recommendations of the state board relating to integrated service delivery.

The provisions of this section shall remain in effect only until January 1, 1986, and as of such date is repealed, unless a later enacted statute, which is chaptered before January 1, 1986, deletes or extends such date.

Establishment of Programs; Plan Requirements; Standards for Procedures; Record System

321.2. The governing body of each county or counties shall establish a community child health and disability prevention program for the purpose of providing early and periodic assessments of the health status of children in the county or counties by July 1, 1974. However, this shall be the responsibility of the department for all counties which contract with the state for health services. Contract counties, at the option of the board of supervisors, may provide services pursuant to this article in the same manner as other county programs, provided such option is exercised prior to the beginning of each fiscal year. Each such plan shall include, but is not limited to, the following requirements:

(a) Outreach and educational services.

(b) Agreements with public and private facilities and practitioners to carry out the programs.

(c) Health screening and evaluation services.

(d) Referral for diagnosis or treatment when needed and methods for assuring referral is carried out.

(e) Recordkeeping and program evaluations.

The health screening and evaluation part of each community child health and disability prevention program plan shall include, but is not limited to, the following for each child:

(a) A health and development history.

(b) An assessment of physical growth.

(c) An examination for obvious physical defects.

(d) Ear, nose, mouth, and throat inspection, including inspection of teeth and gums.

(e) Screening tests for vision, hearing, anemia, tuberculosis, diabetes, and urinary tract conditions.

(f) An assessment of nutritional status.

(g) An assessment of immunization status.

(h) Where appropriate, testing for sickle cell trait, lead poisoning, and other tests which may be necessary to the identification of children with potential disabilities requiring diagnosis and possibly treatment.

Standards for procedures to carry out health screening and evaluation services and to establish the age at which particular tests should be carried out shall be established by the director, with review and recommendation by the board. However, a governing body may include additional health screening and evaluation procedures in its program if approved by the director and the board.

Each community child health and disability prevention program shall, pursuant to standards set by the director, establish a record system which contains a health case history for each child so that costly and unnecessary repetition of screening, immunization and referral will not occur and appropriate health treatment will be facilitated as specified in Section 323.5.

321.7. A local maternal, child, and adolescent health board is hereby established to advise the governing body and the local health officer on local programs and services affecting the health of mothers, children, and adolescents. The local board shall be appointed by the governing body and shall reflect the demographic and ethnic characteristics of the geographic area served. The governing body may constitute local boards on a subcounty or multicounty basis, as appropriate. Local boards shall supersede and incorporate the local child health and disability prevention program advisory board and may supersede and incorporate any other bodies advisory to local government on maternal, child, and adolescent health programs under the jurisdiction of the department. Each local board shall include individuals who are eligible or who are parents of children eligible for health services administered by the department, representatives from health professions and organizations concerned with maternal, child, and adolescent health, a school health representative, members of existing local groups advisory to maternal, child, and adolescent health programs in the jurisdiction, and other individuals interested in the health of mothers and children.

The local health officer shall be responsible for providing support staff and services to the local board from state or federal funding presently utilized for planning and organizing maternal, child, and adolescent health service. Counties shall not be required to expend more funds than presently are being expended for the purpose of this section and shall include such costs in whatever annual maternal child health plan is required for department approval. Local board members shall serve without compensation, except that members shall be reimbursed for actual and necessary expenses incurred in connection with the performance of their duties. Members may additionally be reimbursed upon request to the governing body for their actual and necessary additional costs of child care and lost wages.

The local board shall have all of the following powers, duties and responsibilities:

(a) Review the community's maternal, child, and adolescent health needs and the adequacy of health care services, programs, providers, and facilities to meet those needs.

(b) Review and comment during the development and adoption of the required annual local maternal and child health services plan. The plan should address strategies for coordinating and integrating local maternal, child, and adolescent health programs and planning processes.

(c) Advise the governing body and local health officer on methods of integration at the local level of categorical programs affecting the health of mothers and children, including, but not limited to:

(1) Proposing specific models, including funding levels, which integrate maternal and child health services at the local level which are consistent with state guidelines and the local maternal and child health plan.

(2) Disseminating information on and recommending uses of block grant funding or other innovative financing methods which may be made available to the local jurisdiction.

(3) Monitoring and evaluating model integrated delivery systems as to outcome and cost effectiveness, and recommending termination or continuation of such models based on such review.

(d) Review local health statistics and program data to assess improvement in the overall health status of mothers and children.

(e) Provide formal written input on local maternal, child and adolescent health services and needs to the local health planning agencies for inclusion in plans for health services and local proposed use of public funds.

(f) Represent the concerns of consumers and local service providers in their relationship with the State Department of Health Services.

(g) Serve as a catalyst for policy development by the state board to assure that state policy reflects local needs.

(h) Review and comment to the governing body on local implications of reports, recommendations and actions of the state board. Local individuals and organizations may respond to the actions of the local board in their jurisdiction by submitting written comments to the governing body and local health officer.

The local board may also perform such other duties relating to maternal and child health which may be delegated to it by the governing body.

This section shall remain in effect only until January 1, 1986, and as of such date is repealed, unless a later enacted statute, which is chaptered before January 1, 1986, deletes or extends such date.

Certificate of Receipt; Health Screening and Evaluation Services; Waiver by Parent or Guardian

323.5. On and after July 1, 1976, each child eligible for services under this article shall, within 90 days after entrance into the first grade, provide a certificate approved by the State Department of Health Services to the school in which the child is to enroll documenting that within the prior 18 months the child has received the appropriate health screening and evaluation services specified in Section 321.2. A waiver signed by the child's parents or guardian indicating that they do not want or are unable to obtain such health screening and evaluation services for their children shall be accepted by the school in lieu of the certificate. If the waiver indicates that the parent or guardian was unable to obtain such services for the child, then the reasons why should be included in the waiver.

Education Code sections 49450 and 49456

Rules to Insure Proper Care and Secrecy

49450. The governing board of any school district shall make such rules for the examination of the pupils in the public schools under its jurisdiction as will insure proper care of the pupils and proper secrecy in connection with any defect noted by the supervisor of health or his assistant and may tend to the correction of the physical defect.

Report to Parent

49456. (a) When a defect other than a visual defect has been noted by the supervisor of health or his assistant, a report shall be made to the parent or guardian of the child, asking the parent or guardian to take such action as will cure or correct the defect. Such report, if made in writing, shall not include any recommendation suggesting or directing the pupil to a designated individual for the purpose of curing or correcting any defect referred to in the report.

(b) When a visual defect has been noted by the supervisor of health or his assistant, a report shall be made to the parent or guardian of the child, asking the parent or guardian to take such action as will correct the defect. Such report, if made in writing, must be made on a form prescribed or approved by the Superintendent of Public Instruction and shall not include therein any recommendation suggesting or directing the pupil to a designated individual or class of practitioner for the purpose of correcting any defect referred to in the report.

(c) The provisions of this section do not prevent a supervisor of health from recommending in a written report that the child be taken to a public clinic or diagnostic and treatment center operated by a public hospital or by the state, county, or city department of public health.

Child Health and Disability Prevention Program
Target Populations

INTRODUCTION

CHDP provides reimbursed preventive health services to Medi-Cal beneficiaries from birth through 20 years of age and to children attending Head Start/State Preschool programs, children entering kindergarten and the first grade from low-income families and low birth weight infants from low-income families.

RESIDENCY

A person who is residing in California and (1) is on Medi-Cal or (2) otherwise eligible for CHDP services, is eligible to receive these services in any California county regardless of the person's county of residence. United States citizenship is not a criterion for eligibility.

BENEFITS FOR VARIOUS ELIGIBLE GROUPS

BENEFITS FOR MEDI-CAL-ELIGIBLE CHILDREN

Assessments:

Medi-Cal-eligible persons from birth through 20 years of age are eligible to receive initial and periodic CHDP health assessment services according to their age, sex, and health history.

Diagnosis and Treatment:

Medi-Cal-covered diagnosis and treatment services for eligible persons are reimbursable through the Medi-Cal program. To be reimbursed for such services, the provider must be a Medi-Cal-certified provider and bill the Medi-Cal program.

BENEFITS FOR HEAD START/STATE PRESCHOOL CHILDREN

Assessments:

All Head Start and State Preschool children are eligible for reimbursed CHDP health assessments appropriate for their age and health history. Non Medi-Cal-eligible children will have their health assessments reimbursed only when they are actually participating in classroom activities.

Diagnosis and Treatment:

Diagnosis and treatment services will *not* be reimbursed by the CHDP Program. Non Medi-Cal-eligible children needing these services may have insurance or should be referred to providers who are willing to furnish these services at little or no expense to the child's family, or to appropriate agencies such as California Children Services (CCS), regional centers for the developmentally disabled, etc. Providers may request the assistance of the local program staff in contacting families and helping them with appointments.

BENEFITS FOR FIRST GRADE ENTRANTS[1]

Assessments:

Children who are not certified Medi-Cal-eligible are eligible for ONE state-reimbursed health assessment appropriate to their age and health history if:

1. the child will be entering first grade within the next 18 months or has entered the first grade within the last 90 days, and

2. the child is from a family whose annual cash income from all sources (before taxes) is at or below the income level specified for the size of the family unit in the *Income Eligibility Table*.

Diagnosis and Treatment:

Diagnosis and treatment services will *not* be reimbursed by the CHDP Program. Non Medi-Cal-eligible children needing these services may have insurance or should be referred to providers who are willing to furnish these services at little or no expense to the child's family, or to appropriate agencies such as CCS, regional centers for the developmentally disabled, etc. Providers may request the assistance of the local program staff in contacting families and helping them with appointments.

BENEFITS FOR NON MEDI-CAL-ELIGIBLE LOW BIRTH WEIGHT INFANTS

Assessments:

Low birth weight infants are eligible for state-reimbursed health assessments through 12 months of age if:

1. They weighed 2,500 grams (5 pounds, 8 ounces) or less at birth, and

2. They are less than 13 months of age, and

3. Their family's income is at or below the income level specified in the *Income Eligibility Table*

Diagnosis and Treatment:

Diagnosis and treatment services will *not* be reimbursed by the CHDP Program. Non Medi-Cal-eligible infants needing these services may have insurance or should be referred to providers who are willing to furnish these services at little or no expense to the infant's family, or to appropriate agencies such as CCS, regional centers for the developmentally disabled, etc. Providers may request the assistance of the local program staff in contacting families and helping them with appointments.

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1 For the purpose of CHDP's reimbursement policies, "first grade entrance" is defined as the first time a child is enrolled in the first grade in a California school. Children in ungraded classes are considered as first grade entrants if their sixth birthday comes before December 2 of that school year.

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HEALTH ASSESSMENT PROCEDURES REQUIRED FOR VARIOUS AGE GROUPS[1]

Child Health and Disability Prevention Program

SCREENING PROCEDURE	AGE OF PERSON BEING SCREENED														
	Under 1 Mo.	1–2 Mos.	3–4 Mos.	5–6 Mos.	7–9 Mos.	10–12 Mos.	13–17 Mos.	18–23 Mos.	2 Yrs.	3 Yrs.	4–5 Yrs.	6–8 Yrs.	9–12 Yrs.	13–16 Yrs.	17–20 Yrs.
Interval Until Next Exam	1 Mo.	2 Mos.	2 Mos.	2 Mos.	3 Mos.	3 Mos.	5 Mos.	6 Mos.	1 Yr.	1 Yr.	2 Yrs.	3 Yrs.	4 Yrs.	4 Yrs.	None
HISTORY AND PHYSICAL EXAMINATION Dental Assessment Nutritional Assessment Developmental History and Assessment Health Education	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
VISION SCREENING															
Snellen or Equivalent Visual Acuity Test										X[2]	X	X	X	X	X
Clinical Observation	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
HEARING SCREENING															
Audiometric										X[2]	X	X	X	X	X
Nonaudiometric		X	X	X	X	X	X	X	X	X					
TUBERCULIN TEST[3]						X					X			X	X
LABORATORY TESTS															
Hematocrit or Hemoglobin					X		X		X	X	X		X	X	X
Urine Dipstick or Urinalysis											X	X	X	X	X
Phenylketonuria (PKU)	X														
Sickle Cell	May be done once if both anemic and from specific target groups (see guidelines).														
Free Erythrocyte Protoporphyrin (FEP)	May be done only if health history warrants.														
Blood Lead Level	May be done only if FEP is above 50 μg/dl.														
Gonorrhea Culture[4]													X	X[4]	X
Papanicolau (Pap) Smear														X	X
IMMUNIZATIONS – administer as necessary to make status current.[5]		X	X	X	X	X	X	X	X	X	X	X	X	X	X

NOTE: PERSONS COMING UNDER CARE WHO HAVE NOT RECEIVED ALL THE RECOMMENDED PROCEDURES FOR AN EARLIER AGE SHOULD BE BROUGHT UP-TO-DATE AS APPROPRIATE.

1 Required unless medically contraindicated or deemed inappropriate by the screening provider or refused by the person.
2 Snellen and audiometric examinations should be done at this age if possible.
3 Recommended more frequently in high risk populations such as recent immigrant and refugee families.
4 Recommended only for sexually active adolescents.
5 "Guide For Use of Selected Vaccines and Toxoids," California Department of Health Services, Infectious Disease Section, July 1980.

Reference: CHDP Regulations, Title 17, Section 6846, California Administrative Code.

(Rev. 5/83)

CHILD HEALTH AND DISABILITY PREVENTION PROGRAM
ELIGIBILITY DETERMINATION TABLE
Fiscal Year 1983–84

PROVIDERS ARE REQUIRED TO ENSURE THAT THE PARENT UNDERSTANDS THESE AGE AND INCOME REQUIREMENTS BEFORE THE PARENT SIGNS THE PM 160 (NOT APPLICABLE WHEN THE CHILD IS ELIGIBLE FOR MEDI-CAL OR IS ATTENDING A STATE PRESCHOOL OR HEAD START PROGRAM).

Eligibility Criteria:

1. **Medi-Cal**

   Persons from birth through 20 years of age, who are certified as eligible to receive Medi-Cal are also eligible for CHDP reimbursed health assessments. Any subsequent diagnosis and treatment services needed by Medi-Cal eligible persons must be billed through the regular Medi-Cal system.

2. **Head Start and State Preschool**

   Children attending Head Start and State Preschool programs are eligible for CHDP reimbursed health assessments.

3. **School Entrance**

   Children who are *not* certified Medi-Cal eligible and who are *not* enrolled in Head Start or State Preschool programs are eligible for ONE state-reimbursed health assessment if:

   a. The child is entering first grade within the next 18 months or has entered the first grade within the last 90 days, and

   b. The child is from a family whose annual cash income from all sources (before taxes) is at or below the income level specified for the size of the family unit on the Income Eligibility Table below.

4. **Low Birth Weight Infants**

   Low birth weight infants are eligible for state-reimbursed health assessments if:

   a. The infant weighed 2,500 grams (5 pounds, 8 ounces) or less *at birth*, and

   b. The infant is under 13 months of age, and

   c. The infant is from a family whose annual cash income from all sources (before taxes) is at or below the income level specified for the size of the family unit on the Income Eligibility Table below.

INCOME ELIGIBILITY TABLE, Fiscal Year 1983–84		
Number Of Persons In Family Unit	INCOME*	
	Annual	Monthly
1	$ 6,192	$ 516
2	10,176	848
3	12,624	1,052
4	15,000	1,250
5	17,112	1,426
6	19,248	1,604
7	21,120	1,760
8	23,016	1,918
9	24,960	2,080
10	27,120	2,260
more than 10	$216 per additional family member	$18 per additional family member

* Figures are 200% of the State Department of Social Services AFDC Minimum Basic Standard of Adequate Care for Fiscal Year 1983–84.

PROGRAMA DE SALUD PARA LA PREVENCION DE INCAPACIDADES EN NIÑOS Y JOVENES (CHILD HEALTH AND DISABILITY PREVENTION PROGRAM) TABLA QUE DETERMINA LA ELEGIBILIDAD

Año Fiscal 1983–84

SE LES PIDE A LOS PROVEEDORES QUE SE ASEGUREN QUE EL PADRE/LA MADRE ENTIENDEN ESTOS REQUISITOS DE LA EDAD E INGRESOS ANTES QUE EL/ELLA FIRMEN EL FORMULARIO PM 160 (ESTO NO SE APLICA CUANDO EL NIÑO/LA NIÑA SON ELEGIBLES PARA MEDI-CAL O ESTAN ASISTIENDO A PROGRAMAS PREESCOLARES (STATE PRESCHOOL OR HEAD START PROGRAM)).

Criterio para Elegibilidad:

1. **Medi-Cal**

   Las personas que prueban que desde su nacimiento hasta los 20 años de edad son elegibles para recibir Medi-Cal, son también elegibles para los reembolsos de avaluación de la salud CHDP. Cualquier diagnóstico y tratamiento subsiguientes que necesiten las personas elegibles para Medi-Cal deben ser cargados a través del sistema regular de Medi-Cal.

2. **Programas Preescolares (Head Start and State Preschool)**

   Los niños que concurren a los programas preescolares (Head Start and State Preschool) son elegibles para el reembolso de avaluación de la salud CHDP.

3. **Ingreso Escolar**

   Los niños que *no* prueban que son elegibles para Medi-Cal y que *no* están matriculados en los programas preescolares (Head Start or State Preschool) son elegibles para el reembolso de UNO de los servicios estatales de avaluación de la salud si:

   a. El niño ingresa al primer grado dentro de los próximos 18 meses o ha ingresado al primer grado dentro de los últimos 90 días, y

   b. El niño pertenece a una familia cuyo ingreso total por año (antes de los impuestos) es igual o menor al ingreso especificado para el número de miembros en la familia, tal como se indica más abajo en la Tabla de Ingresos para Elegibilidad.

4. **Criaturas de Poco Peso al Nacer**

   Las criaturas de poco peso al nacer son elegibles para reembolsos estatales de avaluación de la salud si:

   a. La criatura pesó *al nacer* 2,500 gramos (5 libras, 8 onzas) o menos,

   b. La criatura es menor de 13 meses de edad, y

   c. La criatura pertenece a una familia cuyo ingreso total anual (antes de los impuestos) es igual o menor al ingreso especificado para el número de miembros en la familia, tal como se indica más abajo en la Tabla de Ingresos para Elegibilidad.

TABLA DE INGRESOS PARA ELEGIBILIDAD. Año Fiscal 1983–84

Número de Personas en una Familia	INGRESO*	
	Anual	Mensual
1	$ 6,192	$ 516
2	10,176	848
3	12,624	1,052
4	15,000	1,250
5	17,112	1,426
6	19,248	1,604
7	21,120	1,760
8	23,016	1,918
9	24,960	2,080
10	27,120	2,260
más de 10	$216 por miembro adicional en la familia	$18 por miembro adicional en la familia

Los cálculos son 200% del Departamento de Servicios Sociales del Estado por Asistencia a Familias con Niños Necesitados (Aid to Families with Dependent Children (AFDC)) Criterio Mínimo Básico de Cuidado Adecuado (Minimum Basic Standard of Adequate Care) para al Año Fiscal 1983–84.

Appendix B

Mandatory Hearing Examinations

Education Code sections 49451, 49452, and 49454

Parent's Refusal to Consent

49451. A parent or guardian having control or charge of any child enrolled in the public schools may file annually with the principal of the school in which he is enrolled a statement in writing, signed by the parent or guardian, stating that he will not consent to a physical examination of his child. Thereupon the child shall be exempt from any physical examination, but whenever there is a good reason to believe that the child is suffering from a recognized contagious or infectious disease, he shall be sent home and shall not be permitted to return until the school authorities are satisfied that any contagious or infectious disease does not exist.

Sight and Hearing Test

49452. The governing board of any school district shall, subject to Section 49451, provide for the testing of the sight and hearing of each pupil enrolled in the schools of the district. The test shall be adequate in nature and shall be given only by duly qualified supervisors of health employed by the district; or by certificated employees of the district or of the county superintendent of schools who possess the qualifications prescribed by the Commission for Teacher Preparation and Licensing; or by contract with an agency duly authorized to perform such services by the county superintendent of schools of the county in which the district is located, under guidelines established by the State Board of Education; or accredited schools or colleges of optometry, osteopathy, or medicine. The records of the tests shall serve as evidence of the need of the pupils for the educational facilities provided physically handicapped individuals. The equipment necessary to conduct the tests may be purchased or rented by governing boards of school districts. The state, any agency, or political subdivision thereof may sell or rent any such equipment owned by it to the governing board of any school district upon such terms as may be mutually agreeable.

Use of Audiometer

49454. A person employed by a school district in a position requiring certification qualifications who holds a valid special credential authorizing the teaching of lipreading or the teaching of the deaf and hard of hearing or a standard teaching credential with specialized preparation in the area of the deaf and hard of hearing or in the area of the speech and hearing handicapped or who holds a certificate of registration to serve as a school audiometrist issued by the State Department of Health Services may, subject to Section 49451, test the hearing of pupils of the district through the use of an audiometer for the purpose of detecting pupils with impaired hearing.

California Administrative Code, Title 17, Public Health, sections 2950 and 2951

2950. Qualifications.

The qualifications required for registration as school audiometrist shall be as follows:

(a) Satisfactory completion of required training in audiology and audiometry at an accredited university or college. Such training must include a minimum of eight quarter hours, or equivalent, academic preparation in audiology and identification audiometry in courses approved by the State Department of Health. If the applicant completed the required training more than five years prior to the date of application for registration, he must have had at least one year of verified supervised experience in the interim in the administration of hearing tests of school children in the public or parochial schools, or in other tax maintained institutions in this State.

(b) For purposes of section (a), accreditation of colleges or universities is by one of the following accrediting associations:

(1) New England Association of Colleges and Secondary Schools.

(2) Middle States Association of Colleges and Secondary Schools.

(3) North Central Association of Colleges and Secondary Schools.

(4) Northwest Association of Secondary and Higher Schools.

(5) Southern Association of Colleges and Secondary Schools.

(6) Western College Association.

(c) All applications for registration as school audiometrist shall be filed in the office of the State Department of Health.

(d) A registration fee of $5 shall accompany such application.

2951. Testing Standards. Pursuant to Health and Safety Code Section 1685 the following standards are determined necessary to insure the adequacy of hearing testing in the schools.

(a) Pure tone audiometers used for testing of hearing shall meet or exceed the current specifications of the American National Standards Institute (ANSI).

(b) Audiometric testing personnel shall maintain continuous surveillance of the instruments used and shall have all audiometers serviced and calibrated at least once a year.

(c) For screening purposes, the adequacy of the testing environment may be determined by qualified audiometric testing personnel. To insure test validity and reliability, air conduction threshold tests shall be conducted in an environment which does not cause a threshold shift greater than 10 decibels at those frequencies which must be included in a pure tone air conduction threshold test.

(d) Each pupil shall be given a screening test in kindergarten or first grade and in second, fifth, eighth and tenth or eleventh grades. Each pupil enrolled in classes for the physically handicapped, educationally handicapped, special education programs or ungraded classes shall be given hearing tests when enrolled in the program and every third year thereafter.

(e) Pure tone audiometric screening tests, either group or individual, shall be conducted at a level not to exceed 25 decibels and shall include the frequencies 1,000, 2,000 and 4,000 Hz. Failure to respond to any of the required frequencies at the screening level constitutes a failure of the screening test.

(f) Pure tone air conduction threshold tests shall include the frequencies 250, 500, 1,000, 2,000, and 4,000 Hz and shall be given to

(1) all pupils who fail the screening tests;

(2) all pupils who are to be considered for further audiological or otological evaluation.

(g) The schools shall provide the parents or guardians of children who fail the hearing tests with a written notification of the test results and recommend that a medical evaluation be obtained whenever the test demonstrates

(1) a hearing level of 30 decibels or greater for two or more frequencies in an ear at 250, 500, 1,000, 2,000, or 4,000 Hz, or a hearing level of 40 decibels or greater for any ONE of the frequencies tested, 250 through 4,000 Hz, on two threshold tests completed at an interval of at least two weeks, or

(2) there is evidence of pathology, e.g., an infection of the outer ear, chronic drainage or a chronic earache.

(h) Dates and the results of all screening tests shall be recorded on each pupil's health record. Copies of all threshold tests shall be filed with the pupil's health record and the cumulative record folder.

(i) An annual report of the school hearing testing program shall be prepared, using forms provided by the State Department of Health. This annual report shall be submitted to the State Department of Health with copies to the district superintendent and the county superintendent of schools.

Appendix C

Mandatory Vision Screening

Education Code sections 49455 and 49456

Vision Appraisal

49455. Upon first enrollment in a California school district of a child at a California elementary school, and at least every third year thereafter until the child has completed the eighth grade, the child's vision shall be appraised by the school nurse or other authorized person under Section 49452. This evaluation shall include tests for visual acuity and color vision; however, color vision shall be appraised once and only on male children, and the results of the appraisal shall be entered in the health record of the pupil. Color vision appraisal need not begin until the male pupil has reached the first grade. Gross external observation of the child's eyes, visual performance, and perception shall be done by the school nurse and the classroom teacher. The evaluation may be waived, if the child's parents so desire, by their presenting of a certificate from a physician and surgeon or an optometrist setting out the results of a determination of the child's vision, including visual acuity and color vision.

The provisions of this section shall not apply to any child whose parents or guardian file with the principal of the school in which the child is enrolling, a statement in writing that they adhere to the faith or teachings of any well-recognized religious sect, denomination, or organization and in accordance with its creed, tenets, or principles depend for healing upon prayer in the practice of their religion.

Report to Parent

49456. (a) When a defect other than a visual defect has been noted by the supervisor of health or his assistant, a report shall be made to the parent or guardian of the child, asking the parent or guardian to take such action as will cure or correct the defect. Such report, if made in writing, shall not include any recommendation suggesting or directing the pupil to a designated individual for the purpose of curing or correcting any defect referred to in the report.

(b) When a visual defect has been noted by the supervisor of health or his assistant, a report shall be made to the parent or guardian of the child, asking the parent or guardian to take such action as will correct the defect. Such report, if made in writing, must be made on a form prescribed or approved by the Superintendent of Public Instruction and shall not include therein any recommendation suggesting or directing the pupil to a designated individual or class of practitioner for the purpose of correcting any defect referred to in the report.

(c) The provisions of this section do not prevent a supervisor of health from recommending in a written report that the child be taken to a public clinic or diagnostic and treatment center operated by a public hospital or by the state, county, or city department of public health.

Appendix D

Mandatory Scoliosis Screening

Education Code Section 49452.5

49452.5. The governing board of any school district shall, subject to Section 49451 and in addition to the physical examinations required pursuant to Sections 208, 321, and 323.7 of the Health and Safety Code, provide for the screening of every female pupil in grade 7 and every male pupil in grade 8 for the condition known as scoliosis. The screening shall be in accord with standards established by the Department of Education. The screening shall be supervised only by qualified supervisors of health as specified in Sections 44871 to 44878, inclusive, and Section 49422, or by school nurses employed by the district or the county superintendent of schools, or pursuant to contract with an agency authorized to perform such services by the county superintendent of schools of the county in which the district is located pursant to Sections 1750 to 1754, inclusive, and Section 49402 of this code, Section 485 of the Health and Safety Code, and guidelines established by the State Board of Education. The screening shall be given only by individuals who supervise, or who are eligible to supervise, the screening, or by certificated employees of the district or of the county superintendent of schools who have received in-service training, pursuant to rules and regulations adopted by the State Board of Education, to qualify them to perform such screenings. It is the intent of the Legislature that such screenings be performed during the regular schoolday and that any staff time devoted to such activities be redirected from other ongoing activities not related to the pupil's health care.

In-service training may be conducted by orthopedic surgeons, physicians, registered nurses, and physical therapists, who have received specialized training in scoliosis detection.

The governing board of any school district shall provide for the notification of the parent or guardian of any pupil suspected of having scoliosis. The notification shall include an explanation of scoliosis, the significance of treating it at an early age, and the public services available, after diagnosis, for treatment. Referral of the pupil and the pupil's parent or guardian to appropriate community resources shall be made pursuant to Sections 49426 and 49456.

No action of any kind in any court of competent jurisdiction shall lie against any individual, authorized by this section to supervise or give a screening, by virtue of the provisions of this section.

Appendix E

Immunizations Required for School Entry and Treatment of Emancipated Minors

Health and Safety Code sections 3380, 3381, and 3389

Legislative Intent

3380. In enacting this chapter, it is the intent of the Legislature to provide:

(a) A means for the eventual achievement of total immunization of appropriate age groups against diphtheria, pertussis, tetanus, poliomyelitis, measles, mumps, and rubella.

(b) That the persons required to be immunized be allowed to obtain immunizations from whatever medical source they so desire, subject only to the condition that the immunization be performed in accordance with the regulations of the State Department of Health Services and that a record of the immunization is made in accordance with such regulations.

(c) Exemptions from immunization for medical reasons or because of personal beliefs.

(d) For the keeping of adequate records of immunization so that health departments, schools, and other institutions, parents or guardians, and the persons immunized will be able to ascertain that a child is fully or only partially immunized, and so that appropriate public agencies will be able to ascertain the immunization needs of groups of children in schools or other institutions.

Unconditional Admission to School; Governing Authority

3381. As used in this chapter, the term "governing authority" means the governing board of each school district or the authority of each other private or public institution responsible for the operation and control of the institution or the principal or administrator of each school or institution.

The governing authority shall not unconditionally admit any person as a pupil of any private or public elementary or secondary school, child care center, day nursery, nursery school, or development center, unless prior to his or her first admission to that institution he or she has been fully immunized against diphtheria, pertussis (whooping cough), tetanus, poliomyelitis, measles, mumps, and rubella in the manner and with immunizing agents approved by the state department, except that all students who have reached the age of seven shall not be required to be immunized against pertussis or mumps.

Persons already enrolled in California public or private schools at the kindergarten level or above as of January 1, 1980, shall be exempt from the rubella immunization requirement for school attendance until they transfer to, enter, or attend a school at the seventh and ninth grade levels. Students entering the ninth grade on or after February 1, 1985, need not be screened for rubella. Students entering the seventh grade on or after February 1, 1987, need not be screened for rubella.

Documentary Proof of Status; Recording; Review of Conditional Admissions; Prohibiting Attendance; Report on New Entrants; Access to Determine Deficiencies; Cooperation with County Health Officer; Authority to Administer

3389. (a) The governing authority of each school or institution included in Section 3381 shall require documentary proof of each entrant's immunization status. The governing authority shall record the immunizations of each new entrant in the entrant's permanent enrollment and scholarship record on a form provided by the state department. The immunization record of each new entrant admitted conditionally shall be reviewed periodically by the governing authority to ensure that within the time periods designated by regulation of the state

department he or she has been fully immunized against all of the diseases listed in Section 3381, and such immunizations received subsequent to entry shall be added to the pupil's immunization record.

(b) The governing authority of each school or institution included in Section 3381 shall prohibit from further attendance any pupil admitted conditionally who failed to obtain the required immunizations within the time limits allowed in the regulations of the state department, unless the pupil is exempted under Section 3385 or 3386, until that pupil has been fully immunized against all of the diseases listed in Section 3381.

(c) The governing authority shall file a written report on the immunization status of new entrants to the school or institution under their jurisdiction with the state department and the local health department at times and on forms prescribed by the state department. As provided in paragraph (4) of subdivision (a) of Section 49076 of the Education Code, the local health department shall have access to the complete health information as it relates to immunization of each student in the schools or other institutions listed in Section 3381 in order to determine immunization deficiencies.

(d) The governing authority shall cooperate with the county health officer in carrying out programs for the immunization of persons applying for admission to any school or institution under its jurisdiction. The governing board of any school district may use funds, property, and personnel of the district for that purpose. The governing authority of any school or other institution may permit any licensed physician or any qualified registered nurse as provided in Section 2727.3 of the Business and Professions Code to administer immunizing agents to any person seeking admission to any school or institution under its jurisdiction.

Civil Code sections 34.6 and 34.7

34.6 Minors; Contracts Not Disaffirmable; Hospital, Medical, Surgical or Dental Care

Notwithstanding any other provision of law, a minor 15 years of age or older who is living separate and apart from his parents or legal guardian, whether with or without the consent of a parent or guardian and regardless of the duration of such separate residence, and who is managing his own financial affairs, regardless of the source of his income, may give consent to hospital care or any X-ray examination, anesthetic, or medical or surgical diagnosis or treatment to be rendered by a physician and surgeon licensed under the provisions of the State Medical Practice Act, or to hospital care or any X-ray examination, anesthetic, dental or surgical diagnosis or treatment to be rendered by a dentist licensed under the provisions of the Dental Practice Act. Such consent shall not be subject to disaffirmance because of minority.

The consent of the parent, parents or legal guardian of such a minor shall not be necessary in order to authorize such hospital, medical, dental, or surgical care and such parent, parents or legal guardian shall not be liable for any care rendered pursuant to this section.

A physician and surgeon or dentist may, with or without the consent of the minor patient, advise the parents, parent or legal guardian of such minor of the treatment given or needed if the physician and surgeon or dentist has reason to know, on the basis of the information given him by the minor, the whereabouts of the parents, parent or legal guardian.

34.7 Minors; Diagnosis or Treatment of Communicable or Sexually Transmitted Diseases; Consent Not Disaffirmable

Notwithstanding any other provision of law, a minor 12 years of age or older who may have come into contact with any infectious, contagious, or communicable disease may give consent to the furnishing of hospital, medical and surgical care related to the diagnosis or treatment of such disease, if the disease or condition is one which is required by law or regulation adopted pursuant to law to be reported to the local health officer, or a related sexually transmitted disease, as may be determined by the State Director of Health Services. Such consent shall not be subject to disaffirmance because of minority. The consent of the parent, parents, or legal guardian of such minor shall not be necessary to authorize hospital, medical and surgical care related to such disease and such parent, parents, or legal guardian shall not be liable for payment for any care rendered pursuant to this section.

ADMISSION STATUS AND FOLLOW-UP GUIDE

(Based on the legal immunization requirements found in sections 6020 and 6035 of the California Administrative Code, Title 17, Health)

Type of Vaccine Required	How Many Doses Has the Child Had?	Is the Requirement Met?	FOLLOW-UP GUIDE			
			If the Previous Dose Was:	Then the Deadline For the Next Dose Is:		
				Within 10 School Days	8 Weeks After Previous Dose	6-12 Months After Previous Dose, or By End of School Year
Any or All Vaccine(s)	None	No	None	Yes[5]		
Measles[1] Rubella[2] Mumps[2]	One	Yes, unless the dose was received before the child's first birthday.	Received before the first birthday	Yes		
Polio[3] DTP/Td[4]	One	No	More than six weeks ago	Yes		
			Less than six weeks ago		Yes	
DTP/Td	Two	No	More than six weeks ago	Yes		
			Less than six weeks ago		Yes	
Polio[3]	Two	No	More than a year ago	Yes		
			Less than a year ago			Yes
DTP/Td[4]	Three	No	More than a year ago	Yes		
			Less than a year ago			Yes
Polio[3]	Three or more	Yes, unless the last dose was received before the child's second birthday.	Received before the second birthday	Yes		
DTP/Td[4]	Four or more					

1 If a doctor provides a signed statement that the student had measles disease, the requirement is met.

2 For children who entered any California public or private kindergarten or first grade prior to January 1, 1980, rubella and mumps immunizations are not required, even when entering or transferring to a new school. Children who did not attend kindergarten and enter school at the first grade level after January 1, 1980, must meet the rubella and mumps requirement. If a doctor provides a signed statement that the child had laboratory proven mumps or rubella disease, the corresponding requirement is met.

3 Polio vaccine is usually trivalent oral polio vaccine (TOPV, or Sabin vaccine). Inactivated polio vaccine (IPV, or Salk vaccine), is rarely given. For IPV, follow the Guide above as for DTP/Td.

4 A very few children are not given pertussis vaccine for medical reasons. For any combination of DTP and Td or DT vaccine, follow the Guide as for DTP/Td. If the child has received Td or DT exclusively (that is, no doses of DTP), only three doses are required. Td or DT satisfy the requirements, but Tetanus Toxoid (T) by itself (sometimes used for wound management) does not, and it should not be counted as a Td dose.

5 If a child has received none or only some of the required immunizations, s/he need receive only the first (or next) dose of any one of the required vaccines within 10 school days.

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Appendix F

Dental Health Education and Dental Disease Prevention Programs for Children

Education Code Section 51202

Instruction in Personal and Public Health and Safety

51202. The adopted course of study shall provide instruction at the appropriate elementary and secondary grade levels and subject areas in personal and public safety and accident prevention, including emergency first aid instruction, instruction in hemmorhage control, treatment for poisoning, resuscitation techniques, and cardiopulmonary resuscitation when appropriate equipment is available; fire prevention; the protection and conservation of resources, including the necessity for the protection of our environment; and health, including venereal disease and the effects of alcohol, narcotics, drugs, and tobacco upon the human body.

Health and Safety Code sections 360 through 373

Article 4.5. Dental Disease Prevention Programs for Children
(Article 4.5 added and repealed by Stats. 1979, Ch. 1134. Repeal operative December 31, 1986)

360. The Legislature finds that 95 percent of all children in California have dental disease in the form of dental caries and periodontal disease. Dental disease in childhood can and does result in significant lifetime disability, dental pain, missing teeth, periodontal disease, and the need for dentures. Poor nutrition in childhood is a major contributing factor in lifetime dental disability. The cost of treating the results of dental disease is on the increase and may exceed five hundred million dollars ($500,000,000) per year in California, of which one hundred twenty-five million dollars ($125,000,000) would be paid by the State of California.

The Legislature also finds that dental disease in children and the resultant abnormalities in adults can be prevented by education and treatment programs for children. It is the intent of the Legislature in enacting this article to establish for children in kindergarten through sixth grade preventive dental programs which shall be financed and have standards established at the state level and which shall be operated at the local level.

(Added and repealed by Stats. 1979, Ch. 1134. Repeal operative December 31, 1986.)

361. Each local health department may offer a community dental disease prevention program for all school children in kindergarten through sixth grade. The program shall include, but not be limited to, the following:

(a) Educational programs, focused on development of personal practices by pupils, that promote dental health. Emphasis shall include, but not be limited to, causes and prevention of dental diseases, nutrition and dental health, and the need for regular dental examination with appropriate repair of existing defects.

(b) Preventive services including, but not limited to, plaque control and supervised application of topical prophylactic agents for caries prevention, in accordance with the provisions of Chapter 11 (commencing with Section 3500) of Division 4. Services shall not include dental restoration, orthodontics, or extraction of teeth. Any acts performed, or services provided, under this article constituting the practice of dentistry shall be performed or provided by, or be subject to the supervision of, a licensed dentist in accordance with the provisions of Chapter 4 (commencing with Section 1600) of Division 2 of the Business and Professions Code.

(Added and repealed by Stats. 1979, Ch. 1134. Repeal operative December 31, 1986.)

362. An advisory board, including representatives from education, dental professions, and parent groups shall be designated by the local health department

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to advise on dental health programs. The use of existing advisory bodies is encouraged. The board shall hold public meetings at least twice a year after appropriate notification in order that interested parties may provide input regarding the dental health needs of the community.

(Added and repealed by Stats. 1979, Ch. 1134. Repeal operative December 31, 1986.)

363. The minimal standards of the community dental disease prevention program shall be determined by the state department in accordance with the purposes of this article, and shall be published by the state department on or before March 1, 1980.

(Added and repealed by Stats. 1979, Ch. 1134. Repeal operative December 31, 1986.)

364. The local health officer of each participating local health department or his designee, in cooperation with the appropriate education personnel and the local advisory board, shall submit a proposal for the program to the state department by July 1, 1980. The proposal shall include the methods by which the program will be implemented in each jurisdiction and program results reported. However, this function shall be the responsibility of the state department for all counties which contract with the state for health services under Section 1157. Such contract counties, at the option of the board of supervisors, may provide services pursuant to this article in the same manner as other county programs, provided such option is exercised six months prior to the beginning of each fiscal year, except the first fiscal year.

(Added and repealed by Stats. 1979, Ch. 1134. Repeal operative December 31, 1986.)

364.1. The state department shall review the program proposals and approve programs which meet criteria established pursuant to Section 363. The state department shall, through contractual arrangements, reimburse local health departments with approved programs at an amount of four dollars and fifty cents ($4.50) per participating child in fiscal year 1981–82 for administration and services, pursuant to Section 361. The total local assistance allocation for fiscal year 1981–82 shall not exceed the $1.5 million provided by the 1981 Budget Act. Subsequent reimbursement per participating child shall be determined through the annual budgetary process.

(Added and repealed by Stats. 1979, Ch. 1134. Amended by Stats. 1981, Ch. 949. Repeal operative December 31, 1986.)

364.2. The local health officer may utilize or contract with, or both utilize and contract with, other local public and private non-profit agencies, as well as school districts and county superintendents of schools, in conducting the program. The Legislature recognizes that these agencies, districts, and schools are currently engaged in a limited number of dental disease prevention projects and it is the intent of the Legislature that this participation be continued.

(Added and repealed by Stats. 1979, Ch. 1134. Repeal operative December 31, 1986.)

365. The Department of Education shall assist the state department in developing in-service training programs in dental health and dental disease prevention for kindergarten through sixth grade teachers. The technical content of the training programs shall meet dental standards set by the state department in conjunction with the California Conference of Local Health Officers.

(Added and repealed by Stats. 1979, Ch. 1134. Repeal operative December 31, 1986.)

366. It shall be the responsibility of the governing board of each school district participating in the program and the governing authority of each private school participating in the program to cooperate with the local health officer administering the community dental disease prevention program in carrying out the program in any school under their jurisdiction.

Such governing board or authority shall provide for the school administration to keep participation records for each child and to furnish approved dental health education materials and supplies for plaque control and other required dental disease prevention methods.

Nothing in this article shall require participation by a school district or private school in a program established pursuant to this article.

(Added and repealed by Stats. 1979, Ch. 1134. Repeal operative December 31, 1986.)

367. During the first year of the dental health program, children enrolled in kindergarten through third grade shall be eligible to participate in the program.

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Each year thereafter a grade per year shall be added until kindergarten through sixth grade are included.

(Added and repealed by Stats. 1979, Ch. 1134. Repeal operative December 31, 1986.)

368. (a) On or before July 1, 1981, the local health officer of each participating county or city shall give satisfactory evidence to the state department that each child in kindergarten through third grade, except in schools not offering the program, has participated in the program according to the approved plan unless the child's parent or guardian has given written notice to the governing body of the school district or private school that the child may not participate in the program. Such notice may disapprove the child's participation in all or any portion of the program.

(b) On or before July 1, 1981, and annually thereafter, the local health officer of each participating county or city shall submit to the state department a report on the programs established pursuant to this article. Such report shall contain data specified by the state department and shall include, but not be limited to, the number of participating children, the number of children examined, the number of children requiring dental care, the number of children treated, and the number of children requiring further treatment.

(c) On or before January 1, 1982, and annually thereafter, the state department shall submit to the Legislature a report on all statewide activities pursuant to the programs provided in this article, including, but not limited to, summaries of the report information provided pursuant to subdivision (b) of this section.

(Added and repealed by Stats. 1979, Ch. 1134. Repeal operative December 31, 1986.)

371. It is the intent of the Legislature that the program established by this article shall, in fiscal years subsequent to the fiscal year in which this section is enacted, be funded according to customary budget procedures.

(Added and repealed by Stats. 1979, Ch. 1134. Repeal operative December 31, 1986.)

371.3. It is the intent of the Legislature that priority for funding be given to existing local programs already approved and the remaining available moneys be allocated pursuant to Section 371.5.

(Added by Stats. 1981, Ch. 949.)

371.5. It is the further intent of the Legislature that the program established by this article shall be placed in effect in the areas of greatest identified need as determined by the state department, in cooperation with the Department of Education.

(Added and repealed by Stats. 1979, Ch. 1134. Repeal operative December 31, 1986.)

372. The Legislative Analyst shall conduct an evaluation of the programs provided by this article during the fourth program year, including, but not limited to, the cost effectiveness and the impact on state expenditures for medical and dental care, and submit a report of the evaluation to the Legislature on or before January 1, 1985.

(Added and repealed by Stats. 1979, Ch. 1134. Repeal operative December 31, 1986.)

373. This article shall remain in effect until December 31, 1986, and on such date is repealed, unless a later enacted statute, which is chaptered before such date, deletes or extends such date.

(Added and repealed by Stats. 1979, Ch. 1134. Repeal operative December 31, 1986.)

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Appendix G

Mandatory Nutrition Programs

Education Code sections 49530, 49530.5, 49534, and 49550

Legislative Intent

49530. (a) The Legislature finds that (1) the proper nutrition of children is a matter of highest state priority, and (2) there is a demonstrated relationship between the intake of food and good nutrition and the capacity of children to develop and learn, and (3) the teaching of the principles of good nutrition in schools is urgently needed to assist children at all income levels in developing the proper eating habits essential for lifelong good health and productivity.

(b) It is the policy of the State of California that no child shall go hungry at school or a child development program and that schools and child development programs conducted pursuant to Chapter 2 (commencing with Section 8200) of Part 6 of Division 1 of Title 1 have an obligation to provide for the nutritional needs and nutrition education of all pupils during the schoolday and all children receiving child development services.

"Child Nutrition Entity"

49530.5. As used in this article, "child nutrition entity" means any school district, county superintendent of schools, child development program operated pursuant to Chapter 2 (commencing with Section 8200) or Chapter 2.5 (commencing with Section 8400) of Part 6 of Division 1 of Title 1, local agency, private school, or parochial school, or any other agency which qualifies for federal aid under the federal school lunch program or the federal child nutrition program prescribed, respectively, by Chapter 13 (commencing with Section 1751) and Chapter 13A (commencing with Section 1771) of Title 42 of the United States Code.

Nutrition Education Programs

49534. (a) The Department of Education shall formulate the basic elements of nutrition education programs for child nutrition entities participating in programs established under this article. Such programs shall coordinate classroom instruction with the food service program and shall be of sufficient variety and flexibility to meet the needs of pupils in the total spectrum of education, including early childhood, elementary and secondary schools, special education classes and programs and child development programs.

(b) Nutrition education programs shall be maintained on a project approval basis. The State Board of Education shall establish rules and regulations for nutrition education projects. Such projects shall be approved by the State Board of Education upon recommendation of the Department of Education. County offices of education may apply for and receive funds on behalf of school districts under their jurisdiction in order to implement projects.

Projects may include, but need not be limited to, innovative ways to coordinate the school meal service program with the nutrition education program; development of community resources for purposes of nutrition education; instructional programs for teachers, parents, food service employees; and training and utilization of paraprofessionals to assist the instructional staff.

Free or Reduced-Price Meals

49550. Notwithstanding any other provision of law, each school district and county superintendent of schools maintaining any kindergarten or any of grades 1 to 12 shall, commencing on July 1, 1977, provide for each needy pupil enrolled therein, one nutritionally adequate free or reduced-price meal during each schoolday.*

*Public Law 94-105, the National School Lunch Act and Child Nutrition Act of 1966 with Amendments of 1976, gives further guidance in setting the eligibility levels for free and reduced-price lunches, permanently authorizes the school breakfast programs, extends program eligibility to residential child care institutions and direct program outreach, and divides the Special Food Service program for children and the Child Care Food Program. The Child Care Food program is expanded by extending eligibility and replacing the grant-in-aid funding mechanism with performance funding systems.

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Appendix H

Mandatory Reporting of Child Abuse

Penal Code sections 11156 and 11166

11165. Definitions

As used in this article:

(a) "Child" means a person under the age of 18 years

(b) "Sexual assault" means conduct in violation of the following sections of the Penal Code: Sections 261 (rape), 264.1 (rape in concert), 285 (incest), 286 (sodomy), subdivisions (a) and (b) of Section 288 (lewd or lascivious acts upon a child under 14 years of age), and Sections 288a (oral copulation), 289 (penetration of a genital or anal opening by a foreign object), and 647a (child molestation).

(c) "Neglect" means the negligent treatment or the maltreatment of a child by a person responsible for the child's welfare under circumstances indicating harm or threatened harm to the child's health or welfare. The term includes both acts and omissions on the part of the responsible person.

(1) "Severe neglect" means the negligent failure of a person having the care or custody of a child to protect the child from severe malnutrition or medically diagnosed nonorganic failure to thrive. "Severe neglect" also means those situations of neglect where any person having the care or custody of a child willfully causes or permits the person or health of the child to be placed in a situation such that his or her person or health is endangered, as prescribed by subdivision (d), including the intentional failure to provide adequate food, clothing, or shelter.

(2) "General neglect" means the negligent failure of a person having the care or custody of a child to provide adequate food, clothing, shelter, or supervision where no physical injury to the child has occurred.

For the purposes of this chapter, a child receiving treatment by spiritual means as provided in Section 16508 of the Welfare and Institutions Code or not receiving specified medical treatment for religious reasons, shall not for that reason alone be considered a neglected child.

(d) "Willful cruelty or unjustifiable punishment of a child" means a situation where any person willfully causes or permits any child to suffer, or inflicts thereon, unjustifiable physical pain or mental suffering, or having the care or custody of any child, willfully causes or permits the person or health of the child to be placed in a situation such that his or her person or health is endangered.

(e) "Corporal punishment or injury" means a situation where any person willfully inflicts upon any child any cruel or inhuman corporal punishment or injury resulting in a traumatic condition.

(f) "Abuse in out-of-home care" means situations of physical injury on a child which is inflicted by other than accidental means, or of sexual assault or neglect or the willful cruelty or unjustifiable punishment of a child, as defined in this article, where the person responsible for the child's welfare is a foster parent or the administrator or an employee of a public or private residential home, school, or other institution or agency.

(g) "Child abuse" means a physical injury which is inflicted by other than accidental means on a child by another person. "Child abuse" also means the sexual assault of a child or any act or omission proscribed by Section 273a (willful cruelty or unjustifiable punishment of a child) or 273d (corporal punishment or injury). "Child abuse" also means the neglect of a child or abuse in out-of-home care, as defined in this article.

(h) "Child care custodian" means a teacher, administrative officer, supervisor of child welfare and attendance, or certificated pupil personnel employee of any public or private school; an administrator of a public or private day camp; a licensed day care worker; and administrator of a community care facility licensed to care for children; headstart teacher; a licensing worker or licensing evaluator; public assistance worker; employee of a child care institution including, but not limited to, foster parents, group home personnel and personnel of residential care facilities; a social worker or a probation officer.

(i) "Medical practitioner" means a physician and surgeon, psychiatrist, psychologist, dentist, resident, intern, podiatrist, chiropractor, licensed nurse, dental hygienist, or any other person who is currently licensed under Division 2 (commencing with Section 500) of the Business and Professions Code.

(j) "Nonmedical practitioner" means a state or county public health employee who treats a minor for venereal disease or any other condition; a coroner; a paramedic; a marriage, family, or child counselor; or a religious practitioner who diagnoses, examines, or treats children.

(k) "Child protective agency" means a police or sheriff's department, a county probation department, or a county welfare department.

(l) "Commercial film and photographic print processor" means any person who develops exposed photographic film into negatives, slides, or prints, or who makes prints from negatives or slides, for

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compensation. The term includes any employee of such a person; it does not include a person who develops film or makes prints for a public agency.

(Amended by Stats.1982, c. 905, p. ——, § 1.)

11166. Report; Duty; Time

(a) Except as provided in subdivision (b), any child care custodian, medical practitioner, nonmedical practitioner, or employee of a child protective agency who has knowledge of or observes a child in his or her professional capacity or within the scope of his or her employment whom he or she knows or reasonably suspects has been the victim of child abuse shall report the known or suspected instance of child abuse to a child protective agency immediately or as soon as practically possible by telephone and shall prepare and send a written report thereof within 36 hours of receiving the information concerning the incident. For the purposes of this article, "reasonable suspicion" means that it is objectively reasonable for a person to entertain such a suspicion, based upon facts that could cause a reasonable person in a like position, drawing when appropriate on his or her training and experience, to suspect child abuse.

(b) Any child care custodian, medical practitioner, nonmedical practitioner, or employee of a child protective agency who has knowledge of or who reasonably suspects that mental suffering has been inflicted on a child or his or her emotional well-being is endangered in any other way, may report such known or suspected instance of child abuse to a child protective agency.

(c) Any commercial film and photographic print processor who has knowledge of or observes, within the scope of his or her professional capacity or employment, any film, photograph, video tape, negative or slide depicting a child under the age of 14 years engaged in an act of sexual conduct, shall report such instance of suspected child abuse to the law enforcement agency having jurisdiction over the case immediately or as soon as practically possible by telephone and shall prepare and send a written report of it with a copy of the film, photograph, video tape, negative or slide attached within 36 hours of receiving the information concerning the incident. As used in this subdivision, "sexual conduct" means any of the following:

(1) Sexual intercourse, including genital-genital, oral-genital, anal-genital, or oral-anal, whether between persons of the same or opposite sex or between humans and animals.

(2) Penetration of the vagina or rectum by any object.

(3) Masturbation, for the purpose of sexual stimulation of the viewer.

(4) Sadomasochistic abuse for the purpose of sexual stimulation of the viewer.

(5) Exhibition of the genitals, pubic or rectal areas of any person for the purpose of sexual stimulation of the viewer.

• • • (d) Any other person who has knowledge of or observes a child whom he or she knows or reasonably suspects has been a victim of child abuse may report the known or suspected instance of child abuse to a child protective agency.

• • • (e) When two or more persons who are required to report are present and jointly have knowledge of a known or suspected instance of child abuse, and when there is agreement among them, the telephone report may be made by a member of the team selected by mutual agreement and a single report may be made and signed by such selected member of the reporting team. Any member who has knowledge that the member designated to report has failed to do so, shall thereafter make the report.

• • • (f) The reporting duties under this section are individual, and no supervisor or administrator may impede or inhibit the reporting duties and no person making such a report shall be subject to any sanction for making the report. However, internal procedures to facilitate reporting and apprise supervisors and administrators of reports may be established provided that they are not inconsistent with the provisions of this article.

• • • (g) A county probation or welfare department shall immediately or as soon as practically possible report by telephone to the law enforcement agency having jurisdiction over the case, and to the agency given the responsibility for investigation of cases under Section 300 of the Welfare and Institutions Code, every known or suspected instance of child abuse as defined in Section 11165, except acts or omissions coming within the provisions of paragraph (2) of subdivision (c) of Section 11165, which shall only be reported to the county welfare department. A county probation or welfare department shall also send a written report thereof within 36 hours of receiving the information concerning the incident to any agency to which it is required to make a telephone report under this subdivision.

A law enforcement agency shall immediately or as soon as practically possible report by telephone to the county welfare department and the agency given responsibility for investigation of cases under Section 300 of the Welfare and Institutions Code, every known or suspected instance of child abuse reported to it, except acts or omissions coming within the provisions of paragraph (2) of subdivision (c) of Section 11165, which shall only be reported to the county welfare department. A law enforcement agency shall also send a written report thereof within 36 hours of receiving the information concerning the incident to any agency to which it is required to make a telephone report under this subdivision.

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Appendix I
Comprehensive Health Education

Education Code sections 51202, 51203, 51204, 51210, 51881, 51882, 51890, and 51891

Instruction in Personal and Public Health and Safety

51202. The adopted course of study shall provide instruction at the appropriate elementary and secondary grade levels and subject areas in personal and public safety and accident prevention, including emergency first aid instruction, instruction in hemmorhage control, treatment for poisoning, resuscitation techniques, and cardiopulmonary resuscitation when appropriate equipment is available; fire prevention; the protection and conservation of resources, including the necessity for the protection of our environment; and health, including venereal disease and the effects of alcohol, narcotics, drugs, and tobacco upon the human body.

Instruction on Alcohol, Narcotics and Restricted Dangerous Drugs

51203. Instruction upon the nature of alcohol, narcotics, restricted dangerous drugs as defined in Section 11032 of the Health and Safety Code, and other dangerous substances and their effects upon the human system as determined by science shall be included in the curriculum of all elementary and secondary schools. The governing board of the district shall adopt regulations specifying the grade or grades and the course or courses in which such instruction with respect to alcohol, narcotics, restricted dangerous drugs as defined in Section 11032 of the Health and Safety Code, and other dangerous substances shall be included. All persons responsible for the preparation or enforcement of courses of study shall provide for instruction on the subjects of alcohol, narcotics, restricted dangerous drugs as defined in Section 11032 of the Health and Safety Code, and other dangerous substances.

Course of Study Designed for Pupils' Needs

51204. Any course of study adopted pursuant to this division shall be designed to fit the needs of the pupils for which the course of study is prescribed.

Article 2. Course of Study, Grades 1 to 6

Areas of Study

51210. The adopted course of study for grades 1 through 6 shall include instruction, beginning in grade 1 and continuing through grade 6, in the following areas of study:

(a) English, including knowledge of, and appreciation for literature and the language, as well as the skills of speaking, reading, listening, spelling, handwriting, and composition.

(b) Mathematics, including concepts, operational skills, and problem solving.

(c) Social sciences, drawing upon the disciplines of anthropology, economics, geography, history, political science, psychology, and sociology, designed to fit the maturity of the pupils. Instruction shall provide a foundation for understanding the history, resources, development, and government of California and the United States of America; the development of the American economic system including the role of the entrepreneur and labor; man's relations to his human and natural environment; eastern and western cultures and civilizations; and contemporary issues.

(d) Science, including the biological and physical aspects, with emphasis on the processes of experimental inquiry and on man's place in ecological systems.

(e) Fine arts, including instruction in the subjects of art and music, aimed at the development of aesthetic appreciation and the skills of creative expression.

(f) Health, including instruction in the principles and practices of individual, family, and community health.

(g) Physical education, with emphasis upon such physical activities for the pupils as may be conducive to health and vigor of body and mind, for a total period of time of not less than 200 minutes each 10 schooldays, exclusive of recesses and the lunch period.

(h) Such other studies as may be prescribed by the governing board.

Legislative Declaration and Intent

51881. The Legislature finds and declares that although many of the communicable diseases and environmental hazards which plagued earlier generations have been controlled, major health problems and hazards are prevelent among today's school-age children and youth including the abuse of alcohol, narcotics, and tobacco; emotional instability; forced marriage; self-medication; dental caries; nutritional disorders; suicide; and accidents.

The legislature finds and declares that an adequate health education program in the public schools is essential to continued progress and improvement in the quality of public health in this state, and the Legislature further believes that comprehensive health education, taught by properly trained persons, is effective in the prevention of disease and disability.

It is further the intent of the Legislature that, to the maximum extent possible, the present state-funded projects in the school health unit of the Department of Education shall be redirected to carrying out the provisions of this chapter and maximum use shall be made of existing state and federal funds in the implementation of comprehensive health education.

Report

51882. The Legislative Analyst shall report to the Legislature, by April 1, 1979, on the status of the programs provided for by this chapter in terms of the number of participating school districts, materials distributed and developed, the extent of in-service training and participants, trend of the programs, and similar factors.

Article 2. Definitions

"Comprehensive Health Education Programs"

51890. For the purposes of this chapter, "comprehensive health education programs" are defined as all educational programs offered in kindergarten and grades 1 through 12, inclusive, in the public school system, including in-class and out-of-class activities designed to ensure that:

(a) Pupils will receive instruction to aid them in making decisions in matters of personal, family, and community health, to include the following subjects:

(1) The use of health care services and products.

(2) Mental and emotional health and development.

(3) Drug use and misuse, including the misuse of tobacco and alcohol.

(4) Family health and child development, including the legal and financial aspects and responsibilities of marriage and parenthood.

(5) Oral health, vision, and hearing.

(6) Nutrition.

(7) Exercise, rest, and posture.

(8) Diseases and disorders, including sickle cell anemia and related genetic diseases and disorders.

(9) Environmental health and safety.

(10) Community health.

(b) To the maximum extent possible, the instruction in health is structured to provide comprehensive education in health to include all the subjects in subdivision (a).

(c) There is the maximum community participation in the teaching of health including classroom participation by practicing professional health and safety personnel in the community.

(d) Pupils gain appreciation for the importance and value of lifelong health and the need for each individual's personal responsibility for his or her own health.

"Community Participation"

51891. As used in this chapter, "community participation" means the active participation in the planning, implementation, and evaluation of comprehensive health education by parents, professional practicing health care and public safety personnel, and public and private health care and service agencies.

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Appendix J

Migrant Student Health Record

Date		Page	Student# MNE
08/02/81	MIGRANT STUDENT HEALTH RECORD	1 of 3	10000000 XYZ

Birth data	Place of birth	Legal parents	Current parents
Sex = M	Westside Hospital	Doe, Jose	Doe, Jose
DOB = 03/02/69	P.O. Box 1244	Doe, Maria	Doe, Maria
Ver = B	Clewiston	**Home base**	**Current residence**
Age = 12	FL 12345-0000	1212 East 1st Street	2354 Maple Lane
MB = 2	County: Hillsboro	Clewiston	Bloomsburg
	Country: USA	FL 12345-0000	PA 17815-0000

Recent health providers

ID: MDXYAB	ID: SCIXAA	ID: FLABCD	**Current school**
Date: 07/20/81	Date: 06/11/81	Date: 04/01/81	ID: PACADD
			Date: 08/[illegible]/81
Marion Station MIG Clinic	Northwest Medical Center	Clewiston MIG Clinic	Central Junior High
401 East 8th Street	562 West 6th Street	501 Beale Street	East 8th Street
Marion Station	Columbia	Columbia ION	Bloomsburg
MD 54361-0000	SC 98765-0000	FL 12345-0000	PA 17815-0000
Ph: 502-678-4200	Ph: 817-875-6800	Ph: 508-626-1211	

Problem list

ICD group	Condition	Prob freq	Earliest incidence Prov	Enc #	Date	Latest incidence Prov	Enc #	Date
	Chronic							
493	Asthma	1				FLABCD	134979	04/01/81
475	Peritonsillar abscess	2	FLABCD	379429	03/05/78	SCIXAA	796049	06/11/81
	Acute							
034	Streptococcal sore throat and scarlet fever	1				MDXYAB	796049	07/20/81

Patient history

V12 Personal history of certain other diseases
06/01/81 ENC - 127659 - Reported for SCIXAA by SCIXAA
ICD - V12.6 - Diseases of respiratory system

V15 Other personal history presenting hazards to health
06/01/81 ENC - 127659 - Reported for SCIXAA by SCIXAA
ICD - V15.0 - Allergy, other than to medicinal agents

Family history

V17 Family history of certain chronic disabling diseases
06/01/81 ENC - 127659 - Reported for SCIXAA by SCIXAA
ICD - V17.41 - Hypertension

V18 Family history of certain other specific conditions
06/01/81 ENC - 127659 - Reported for SCIXAA by SCIXAA
ICD - V18.0 - Diabetes Mellitus

Screening data and labs

V72 Special investigations and examinations
06/01/81 ENC - 127659 - Reported for SCIXAA by SCIXAA
ICD - V72.80 - Height
CPT - 90751 - Initial history and examination (age 12 through 17 years)

*****Screening data and labs continued next page*****

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Date		Page	Student# MNE
08/02/81	MIGRANT STUDENT HEALTH RECORD	2 of 3	10000000 XYZ

Screening data and labs *****continued*****

Outcome - 58 inches
ICD - V72.81 - Weight
CPT - 90751 - Initial history and examination (age 12 through 17 years)
Outcome - 95 lbs

07/10/81 ENC - 134561 - Reported for MDXYAB by MDXYAB
ICD - V72.2 - Dental examination
ENC - 90751 - Initial history and examination (age 12 through 17 years)
Outcome - Normal

V81 Special screening for cardiovascular, respiratory, and genitourinary diseases
06/01/81 ENC - 127659 - Reported for SCIXAA by SCIXAA
ICD - V81.1 - Blood pressure
CPT - 90751 - Initial history and examination (age 12 through 17 years)
Outcome - 106/66
ICD - V81.21 - Pulse
CPT - 90751 - Initial history and examination (age 12 through 17 years)
Outcome - 78
ICD - V81.5 - Urinalysis
CPT - 81000 - Urinalysis, routine
Outcome - Normal

Immunization data

V04 Need for prophylactic vaccination and inoculation against certain viral diseases
ICD - V04.01 - Polio oral
06/10/70 ENC - 123451 - Reported for FLABCD by FLABCD on 08/02/75 **Resolved**
08/23/70 ENC - 123451 - Reported for FLABCD by FLABCD on 08/02/75 **Resolved**
11/10/71 ENC - 123451 - Reported for FLABCD by FLABCD on 08/02/75 **Resolved**
08/02/75 ENC - 123451 - Reported for FLABCD by FLABCD on 08/02/75 **Resolved**

V06 Need for prophylactic vaccination and inoculation against combinations of diseases
ICD - V06.1 - Diphtheria-Tetanus-Pertussis, combined(DTP)
06/10/70 ENC - 123451 - Reported for FLABCD by FLABCD on 08/02/75 **Resolved**
08/23/70 ENC - 123451 - Reported for FLABCD by FLABCD on 08/02/75 **Resolved**
10/31/70 ENC - 123451 - Reported for FLABCD by FLABCD on 08/02/75 **Resolved**
11/10/71 ENC - 123451 - Reported for FLABCD by FLABCD on 08/02/75 **Resolved**
08/02/75 ENC - 123451 - Reported for FLABCD by FLABCD on 08/02/75 **Resolved**
ICD - V06.4 - Measles-Mumps-Rubella (MMR)
07/01/71 ENC - 123451 - Reported for FLABCD by FLABCD on 08/02/75 **Resolved**

Listing of health problems by problem type and encounter date

Unresolved chronic
475 Peritonsillar abscess
03/05/78 ENC - 379429 - Reported for FLABCD by FLABCD **Resolved**
ICD - 475 - Peritonsillar abscess
CPT - 42700 - Incision and drainage abscess; peritonsillar
Outcome - Normal
RX - Triomycin

06/11/81 ENC - 796049 - Reported for SCIXAA by SCIXAA
ICD - 475 - Peritonsillar abscess
CPT - 42700 - Incision and drainage abscess; peritonsillar
Outcome - Normal
CPT - 42720 - Retropharyngeal or parapharyngeal, intraoral approach
Outcome - Normal
RX - Triomycin

493 Asthma
04/01/81 ENC - 134979 - Reported for FLABCD by FLABCD
ICD - 493.1 - Intrinsic asthma
CPT - 31620 - Bronchoscopy-diagnostic, rigid bronschoscope
Outcome - Normal
RX - Dextromethorphan

*****Listing of health problems continued next page*****

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Date		Page	Student# MNE
08/02/81	MIGRANT STUDENT HEALTH RECORD	3 of 3	10000000 XYZ

Listing of health problems by problem type and encounter date *****continued*****

Unresolved acute

034 Streptococcal sore throat and scarlet fever

07/20/81	ENC - 796049	- Reported for MDXYAB by MDXYAB	
	ICD - 034.0	- Streptococcal sore throat	
	CPT - 87060	- Throat culture	
	Outcome	- Abnormal - follow-up 08/01/81	
	RX	- Ampicillin	

Resolved

474 Chronic disease of tonsils and adenoids

04/06/76	ENC - 987659	- Reported for FLABCD by FLABCD	
	ICD - 474.0	- Chronic tonsillitis	
	CPT - 90010	- New patient - limited service	
	Outcome	- Follow-up on 04/21/76	
	RX	- Erythomycin	
04/21/76	ENC - 674319	- Reported for FLABCD by FLABCD	**Resolved**
	ICD - 474.0	- Chronic tonsillitis	
	CPT - 90050	- Established patient - limited service	
	Outcome	- Normal	

692 Contact dermatitis and other eczema

05/05/77	ENC - 621349	- Reported for FLABCD by FLABCD	**Resolved**
	ICD - 692.6	- Dermatitis due to plants	
	CPT - 90050	- Established patient - limited service	
	Outcome	- Normal	
	RX	- Calamine lotion	
	RX	- Benadryl capsules	

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HEALTH DATA ENTRY FORM

Provider ID: PAWXYZ Reporter ID: PAWXYZ
Student #: 10000000 XYZ Client name: (last) Doe (first) John (MI) L Sex: M
Date of Enc: 08-03-81 Date of birth: 03-02-70 Address: 2354 Maple Lane Bloomsburg St: PA ZIP: 17815
Encounter #: 344634 Legal parent: (last) Doe (first) Jose (last) Doe (first) Maria

Patient history		Yes/No
V10	Malignant neoplasm	
V12.01	Measles	
V12.02	Rubella	
V12.03	Mumps	
V12.04	Chicken pox	
V12.05	Whooping cough	
V12.06	TB	
V12.21	Diabetes	
V12.3	DS BL & organs	
V12.4	DS NS & organs	
V12.41	Epilepsy	
V12.5	DS cir system	
V12.51	Rheumatic fever	
V12.6	DS resp system	
V12.7	DS digestive system	
V13.0	DS urinary	
V14	Allergy med agent	
V15.0	Allergy other agent	

Family history		
V16	Malignant neoplasm	
V17.1	Stroke	
V17.2	DS of nervous sys	
V17.21	Epilepsy	
V17.3	Ischemic heart DS	
V17.4	Other cardiovas DS	
V17.41	Hypertension	
V17.6	DS of resp system	
V17.7	Arthritis	
V18.0	Diabetes mellitus	
V18.6	Kidney DS	
V19.6	Allergic disorder	

Immunization		Check	Batch #	Date	Date	Date
V03.1	Typhoid-paratyp					
V03.2	Tuberculosis (BCG)					
V03.6	Pertussis alone					
V03.7	Tetanus tox. alone					
V04.01	Polio oral					
V04.02	Polio immunization					
V04.1	Smallpox					
V04.2	Measles alone					
V04.3	Rubella alone					
V04.6	Mumps alone					
V04.8	Influenza					
V06.1	DTP					
V06.11	DT					
V06.4	MMR					

Screens/Labs		Check	No: Abn	Outcome
V70.5	Health exam			
V71.2	TB Xray			
V72.0	Gen. vision exam			
V72.1	Gen. hearing exam			
V72.2	Dental exam			
V72.80	Height			(cm) (in)
V72.81	Weight			(kg) (lbs)
V72.82	Head circumference			(cm) (in)
V74.1	TB skin	X	nor	(pos) (neg) X (wheelsize-mm)
V75	Parasitic screen			
V78.0	Hematocrit	X	nor	
V78.2	Sickle-cell			
V80.2	Eyes ext/optic fun			
V80.3	Ears ext/canal			
V81.1	Blood pressure			/
V81.2	Heart			
V81.21	Pulse			
V81.4	Lungs			
V81.5	Urinalysis			
V82.0	Skin			
V82.5	Blood			
V82.9	Scoliosis			

Health problems

Primary	ICD code	Type	Status	EH codes	CPT	A/N/U	Outcome	RX or batch #
X	034.0	Acute	Unr		87060		Follow-up 8-13-81	Erythromycin
X	110.9	Acute	Res		90751			Tinactin ointment

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Publications Available from the Department of Education

Approximately 500 are available from the California State Department of Education. Some of the more recent publications or those most widely used are the following:

Administration of the School District Budget (1983)	$3.00
American Indian Education Handbook (1982)	3.50
Arts for the Handicapped Trainer's Manual (1982)	6.50
Bilingual-Crosscultural Teacher Aides: A Resource Guide (1984)	3.50
California Private School Directory	9.00
California Public School Directory	12.50
Career/Vocational Assessment of Secondary Students with Exceptional Needs (1983)	4.00
Child Development Program Guidelines (1983)	3.75
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